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No. 95-1427

In The

Supreme Court of the United States

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October Term, 1995

RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Petitioner,

vs.

RICHARD C. SURLES, Ph.D., Commissioner of the Office of Mental Health of the State of New York and MICHAEL J. DOWLING, Commissioner of the Department of Social Services of the State of New York,

Respondents.

Petition for a Writ of Certiorari to the New York Supreme Court, Appellate Division, Third Department

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PETITION FOR A WRIT OF CERTIORARI

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85 pp

QUESTIONS PRESENTED

1. Is the State of New York in procedural and substantive violation of the Boren Amendment to the Medicaid Act by reason of its failure to pay federal and state funds to disproportionate share hospitals as required by Congress?

2. Does the payment by New York State of a Disproportionate Share Adjustment to state-owned psychiatric hospitals while denying it to private psychiatric hospitals result in the denial of equal protection and due process of law under the Fourteenth Amendment to the United States Constitution?

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Rye Psychiatric Hospital Center Inc.[1] petitions for a writ of certiorari to review the judgment of the Appellate Division - Third Department of the Supreme Court of the State of New York.

OPINIONS BELOW

The opinion and order of the Appellate Division - Third Department, of the New York State Supreme Court (Appendix 2a-7a) is reported at 630 N.Y.S. 2d 593 (3d Dep't 1995). The order of the New York State Court of Appeals (Appendix 1a) denying Petitioner's motion for leave to appeal is not yet reported. The opinion of the New York State Supreme Court, Albany County (Appendix 10a-17a) is unreported. The judgment of the Supreme Court, Albany County (Appendix 8a-9a) was entered on November 5, 1993.

STATEMENT OF JURISDICTION

The order of the Court of Appeals denying Petitioner's motion for leave to appeal from the order of the Appellate Division - Third Department was made and entered on December 7, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257.

STATUTORY PROVISIONS INVOLVED

This case involves Section 1 of the Fourteenth Amendment to the United States Constitution and provisions of the federal Medicaid Act, Titles XVIII and XIX of the Social Security Act, As Amended, §§ 1902(a)(13)(A), and 1923(a)-(e), 42 U.S.C. §§ 1396a(a)(13)(A) and 1396r-4(a)-(e), the relevant provisions of the Medicaid Act are reproduced in the Appendix.

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[1] There are no parent or subsidiary companies of Rye Psychiatric Hospital Center, Inc., to be listed pursuant to Supreme Court Rule 29.6.

STATEMENT OF THE CASE

Rye Psychiatric Hospital Center, Inc. ("RPHC" or the "Hospital"), is a private freestanding psychiatric hospital located in Rye, New York and is licensed by the New York State Office of Mental Health under Article 31 of the New York Mental Hygiene Law.

At all relevant times the Hospital's patients have included individuals whose medical treatment — with federal financial participation ("FFP") — is the financial responsibility of the State of New York under the Medicaid program (Title XIX of the Social Security Act), 42 U.S.C. § 1396 *et seq*. At all relevant times, RPHC has been an "intended beneficiar[y]" of the Boren Amendment to the Medicaid Act (Title XIX, § 1902(a)(13)(A)) pursuant to the opinion of this Court in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498, 510 (1990).

In July, 1991, as a result of a federal court challenge by RPHC, an Office of Mental Health regulation providing for substantially reduced Medicaid reimbursement for a hospital operating at less than seventy-five percent of its certified capacity, was held to be procedurally null and void pursuant to the requirements of § 1902(a)(13)(A) (hereafter "the Boren Amendment" or "*Boren*") (42 U.S.C. § 1396a(a)(13)(A)). *Rye Psychiatric Hospital Center, Inc. v. Surles*, 768 F. Supp. 82 (S.D.N.Y. 1991). In addition, RPHC had challenged the State's failure on a substantive basis to pay the disproportionate share adjustment ("DSA") required by the Boren Amendment.

For reasons that are clear on the record below, the district court's order regarding the need for the State to first cure its procedural violation delayed the court from addressing the "remaining challenges," which included the DSA. Since the Boren Amendment provides in relevant part that in order to qualify for federal financial participation a state's Medicaid plan must provide for payments to hospitals "which take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs. . . . ," the district court held that

> [t]he disproportionate share adjustment is not an entirely separate issue from the minimum utilization adjustment we nullified in our earlier decision. To calculate a hospital's low-income utilization rate, the revenues paid to the hospital for patient services under the state Medicaid Plan are factored into the formula. *See*, 42 U.S.C. § 1396r-4(b)(3)(A). . . .
>
> Therefore, as New York must recalculate its reimbursement rates absent the voided adjustment from July 2, 1991 forward . . . so too it should redetermine Rye Psychiatric's proper status as a disproportionate share hospital after July 2, 1991

Rye Psychiatric Hosp. Center, Inc. v. Surles, 777 F. Supp. 1142, 1152 (S.D.N.Y. 1991).

Since the federal court held that the Eleventh Amendment to the United States Constitution precluded an order for payment for periods prior to its July, 1991 order, RPHC sought, in State Supreme Court, to enjoin the continued use of the illegal payment methodology and to recover payments illegally withheld from 1986 to July 2, 1991, and to recover the DSAs due it for those years that the Hospital was a DSH according to the statutory definition. 42 U.S.C. § 1396r-4(b), (c). In the parallel proceeding, the Hospital amended its Petition in the New York State Supreme Court to recover the amount of the underpayments, including the DSA, under 42 U.S.C. § 1983.

And in the Amended Petition, verified on February 7, 1992, RPHC alleged that New York State's failure to pay the DSA violated the federal statute, 42 U.S.C. § 1396a(a)(13)(A) and denied Petitioner due process and equal protection of the laws in violation of the Fifth and Fourteenth Amendments to the United States Constitution.

A. The Special Rule

Respondents alleged that New York State is exempt from the DSA requirement pursuant to 42 U.S.C. § 1396r-4(e), specifically that part of subsection (e) which deems a state plan in compliance with the DSA requirement if "A(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984. . . ." Petitioner challenged whether the State, indeed, had an exemption and, if so, whether such an exemption could release the State from paying RPHC its statutorily enforceable right to receive a DSA pursuant to the Boren Amendment.

In an opinion dated July 17, 1992, the Supreme Court, Albany County did not determine these claims but held that

> the state has failed to provide any evidence that the exemption from the disproportionate share hospital provisions is in fact applied statewide, including private psychiatric and specialty hospitals or that there are any pooling arrangements in effect. Accordingly, a hearing shall be required on the issue of whether petitioner is entitled to the additional 5% compensation based on its status as a disproportionate share hospital.

(Appendix 20a).

That subsequent hearing resulted in an order and judgment denying the Hospital's claim for a DSA (Appendix 8a-17a). With respect to the statutory claim, the hearing court also held that "[T]he state has a special rule exemption which allows it to meet the requirement of payment adjustments to its disproportionate-share hospitals." (citing 42 U.S.C. § 1396r-4(e)) (Appendix 13a). This determination was inapposite to the Petition since, even if the State had an exemption for some hospitals under the special rule, hospitals regulated by the Office of Mental Health were not exempted, nor did the Health Care Financing Administration ("HCFA") rely on that special rule for state-owned psychiatric hospitals' compliance pursuant to *Boren*. Nonetheless, the trial court based its decision on the misperception that the special rule could be applied to deny DSAs to this petitioner.

Continuing in the same vein, with respect to the Hospital's constitutional claims, the court held that

> [t]here is a rational basis for the exclusion of private psychiatric hospitals from the bad debt and charity pooling arrangement. The very nature of public hospitals precludes them from turning patients away and as such, they remain uncompensated for care of the indigent and uninsured. The disproportionate-share payment adjustments serve to reduce this deficit. On the other hand, private psychiatric hospitals are able to turn away patients based on inability to pay and therefore, are reimbursed for 100% of their Medicaid expenses. For these reasons, many, such as Rye, operate at a profit. As such petitioner's equal protection claims must be dismissed.

(Appendix 14a).

The fact is that petitioner never challenged the State's right to exclude psychiatric hospitals from the bad debt and charity care pools. On RPHC's appeal from the judgment entered on the foregoing, the Appellate Division-Third Department, too, held:

> The purpose for providing allowances to general hospitals from the bad debt and charity pools is to cushion the financial losses they sustain from bad debts and the costs of charity care (see, Public Health Law § 2807-c[14][b]). Inasmuch as the record evidence shows that private psychiatric hospitals have a relatively low percentage of uncompensated care patients and are profitable enterprises, and as petitioner offered no proof on this issue, we find that there is a rational basis for excluding private psychiatric hospitals from receiving allowances from the subject pools. Thus we reject petitioner's equal protection argument.

630 N.Y.S. 2d at 596 (Appendix 6a).

The Hospital's motion for permission to appeal to the Court of Appeals was denied (Appendix 1a).

The importance of the issue presented here lies in the fact that the State of New York continues to receive federal Medicaid funds while the state plan is not in compliance with the Boren Amendment. There is no statutory exemption from paying "hospitals which serve a disproportionate number of low income patients . . ." — a DSA. 42 U.S.C. § 1396a(a)(13)(A).

B. The Disproportionate Share Adjustment

The DSA in the Boren Amendment was added by the 1981 amendments to the Social Security Act, §1902(a)(13)(A), 42 U.S.C. § 1396a(a)(13)(A), *see* "Medicare and Medicaid Amendments of 1981," Pub. L. 97-35, § 2173(a)(1)(B)(C) effective August 13, 1981, 95 Stat. 808.

State participation in Medicaid is voluntary, but if a State decides to participate and obtain federal Medicaid funds, it must have an approved plan "which fulfills the conditions specified in subsection (a) of this section, . . ." 42 U.S.C. § 1396a(b); *see also Wilder v. Virginia Hospital Ass'n*, 496 U.S. at 502 (1990). This subsection includes the Boren Amendment.

Wilder held that

> the Act creates a right enforceable by health care providers under § 1983 to the adoption of reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility that provides care to Medicaid patients. The right is not merely a procedural one that rates be accompanied by findings and assurances (however perfunctory) of reasonableness and adequacy, rather the Act provides a substantive right to reasonable and adequate rates as well.

Id. at 509-10.

Under the Act, the DSA is a necessary component of a reasonable and adequate rate.

A 1987 House Committee report succinctly states the reason for the DSA requirement:

> The purpose of this requirement, enacted by the Omnibus Budget Reconciliation Act 1981, P.L. 97-35, was to assure that, precisely because states were given flexibility in establishing payment rates, that those payment rates at a minimum meet the needs of those facilities which, because they do not discriminate in admissions against patients based on source of payment or an ability to pay, serve a large number of Medicaid eligible and uninsured patients who other providers view as financially undesirable. These "disproportionate share" hospitals are an essential element of the Nation's health care delivery system, and the Federal and State governments through the Medicaid program, have an obligation to assure that payment levels assist these facilities in surviving the financial consequences of competition in the health care marketplace.

H.R. Rep. No. 100-391 (I) 100th Cong. 1st Sess. 524 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-344.

A corresponding DSA requirement in Medicare, 42 U.S.C. § 1395ww(a)(2), resulted from congressional recognition that, "[h]ospitals that serve a disproportionate share of low-income patients have higher Medicare costs per case." H.R. Rep. No. 99-241, 99th Cong., 2d Sess. (1985), *reprinted in* 1986 U.S.C.A.A.N. 42, 594. Obviously, the same factors that result in higher costs for poor Medicare patients when present in disproportionate numbers apply equally to the poor, in disproportionate numbers, who are covered by Medicaid. As stated in an earlier House Ways and Means Committee Report, "[c]oncern has been expressed that public and other hospitals that serve such patients [a disproportionately large number of Medicare and low-income individuals] may be more severely ill than average. . . ." H.R. Rep. No. 25, 98th Cong. 141-42 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143,360-361.

Unfortunately, the Secretary of Health and Human Services (the "Secretary"), who was specifically charged by Congress with the task of implementing the DSA as early as 1982, chose not to. From the beginning, the Secretary based her failure to comply on a lack of data demonstrating that such an adjustment was necessary, 47 Fed. Reg. 43285 (1982), and for years the DSA requirement was ignored for all hospitals.

Given this initial stimulus from the Secretary, it is little wonder that the States felt free to ignore the DSA requirement in their Medicaid plans. Congress included a similar directive in the Social Security Act Amendments of 1983. Pub. L. 98-21, § 601(e). Again the Secretary responded that although "explicitly authorized to provide" exemptions, exceptions or adjustments considered necessary to take into account the special needs of DSHs, she had been unable to empirically verify the need for a DSA. 48 Fed. Reg. 39416-17 (1983).

In January, 1984, only partially addressing the congressional admonishment, the Secretary repeated that she had not made special provisions in the Medicare regulations for the special needs of DSH hospitals in the Prospective Payment System (required by subparagraph 1395ww(d)(5)(C)(i)), "because our current data does not show that an adjustment is warranted." 49 Fed. Reg. 276 (1984). In *Redbud Hosp. District v. Heckler*, 1984 WL 2857 *9 (N.D. Ca. July 30, 1984), the court had this response:

> The Secretary was not given the discretion to decide whether such hospitals have special needs; she was given discretion only to decide how best to cope with those special needs Congress had already declared to exist. In ignoring this statutory mandate and refusing to recognize and deal with the needs Congress saw, the Secretary has again abuse [sic] her discretion.

On July 18, 1984, *two year's prior* to enactment of section 1886(d)(5)(F) (which provides, *inter alia*, the Medicare and Medicaid formulae for DSAs (42 U.S.C. §§ 1395ww(d)(5)(F), 1396r-4(c)),[2] Congress ordered the Secretary prior to December 31, 1984 to develop and publish a definition of a DSH and to identify those hospitals meeting such definition. Congress made no reference to whether such definition was to be limited to PPS hospitals. Deficit Reduction Act of 1984 ("DEFRA"), Pub. L. 98-369, § 2315(h) (1984). Though the Secretary published her final PPS regulations in August, 1984, she did not even mention the DEFRA-DSA provisions, or indicate their required application to all hospitals that should qualify — PPS and PPS-exempt. 49 Fed. Reg. 34728 (1984).

In July, 1985, *one year prior* to the enactment of the payment provisions for DSHs under Medicare, the United States District Court for the District of Columbia held that under DEFRA the Secretary had a "clear non-discretionary duty to develop a definition of disproportionate share hospitals and to identify those hospitals to the [Senate Finance and House Ways and Means Committees]." *Samaritan Health Center v. Heckler*, 636 F. Supp. 503, 506 (D.D.C. 1985). That *Good Samaritan* was a

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[2] The inclusion of Medicaid use of this Medicare section was in 1987. SSA, Title XIX, § 1923, Pub. L. 100-203, Title IV, § 4112, 101 Stat. 1330-148.

Medicare, and not Medicaid case is irrelevant to the definition of a DSH, since up to that time there were no DSH payments or payment-defining sections for either Medicare or Medicaid.

When the Secretary finally promulgated a DSH definition on December 31, 1985, the definition was so limited that of the 5,788 Medicare-certified hospitals only 18 had a chance of qualifying. 50 Fed. Reg. 53398-53400. The Secretary continued to maintain that "we believe that there is no currently sufficient evidence to demonstrate that an adjustment is warranted." *Id.* at 53399. It is against this background that Congress, in April of 1986, took the extraordinary step of itself establishing specific DSA formulae and defining a DSH. Pub. L. 99-272, § 9105(a), 42 U.S.C. § 1395ww(d)(5)(F). *See* 42 U.S.C.A. § 1395ww note at 326 (1992). With respect to Medicaid, the 1987 House Committee Report cited a "startling record of noncompliance [that] reflects the indifference, if not hostility, of HCFA and many of the States to the 1981 [DSA] statutory requirement." H.R. Rep. No. 100-391 (I) at 525, 1987 U.S.C.C.A.N. at 2313-345, and passed section 1923 of Medicaid which contained definitions of Medicaid DSHs and used the Medicare formulae for payments to non-PPS hospitals pursuant to the Boren Amendment.

As it had with Medicare, Congress sought to ensure compliance with the Medicaid DSA requirement by the enactment in 1987 of Pub. L. 100-203, 42 U.S.C. § 1396r-4. Subsection (a) of this section provided that a state plan would not be considered to meet the DSA requirement of the Boren Amendment unless by July 1, 1988 the State had submitted to the Secretary a plan amendment defining a DSH (which had to include those hospitals described in the definition found in subsection (b)(1)) and providing for such hospitals an increase in payment described in subsection (c). New York has a bifurcated hospital system, the Department of Health for general hospitals and the Office of Mental Health for psychiatric hospitals (state and private) and makes Medicaid payments to each class of hospital through its Department of Social Services, the "single state agency." 42 U.S.C. § 1396a(a)(5). In 1984, it had no DSA provision under its state plan for the class of public psychiatric hospitals and private psychiatric hospitals (42 U.S.C. § 1396d(i)) (or residential treatment facilities[3]), although it had a pooling arrangement for general hospitals. In 1988 the State submitted its plan amendments 88-29 (state-owned hospitals), 88-30 (private, freestanding hospitals) and 88-31 (residential treatment centers for children [non-hospitals]) (Appendix 23a-38a) in an attempt to satisfy the requirements of the new federal law.

In February, 1990 HCFA suggested to the State that compliance with the DSA requirement might be at least partially avoided by reliance upon the so-called "special rule," 42 U.S.C. § 1396r-4(e) (Appendix 39a-40a).

Acting upon this advice a year-and-a-half after the statutory deadlines for the required submissions, the State withdrew the proposed amendments for private psychiatric hospitals (88-30) and residential treatment facilities (88-31), but left identical amendments in the plan to pay DSAs to state-owned psychiatric hospitals (88-29). The result is that no private psychiatric hospital in the State of New York that fits the statutory definition of a DSH receives the congressionally mandated DSA, no matter how many poor patients it serves, while the State reaps federal DSA funds solely for itself. This is wrong in principle, a violation of the Medicaid Act and an infringement upon RPHCs and similarly situated hospitals' constitutional rights of equal protection and due process.

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[3] Residential treatment facilities for children and youth are not hospitals and their relationship to Boren Amendment requirements is tenuous, at best.

The hearing court drew erroneous, contradictory, as well as unsupported conclusions that (1) the court acknowledged that state-owned psychiatric hospitals were not included in the pooling arrangement. Nonetheless, it found that the State had the right to exclude private psychiatric hospitals from DSAs under the special rule. Yet, the special rule does not provide for DSAs for hospitals not under a pooling arrangement; and (2) because the state hospitals need the money more, they may permissibly, receive FFP for DSAs.[4] Nothing in the special rule or the Boren Amendment addresses such considerations. The basis of RPHC's exclusion from DSAs was solely that a pooling arrangement for general hospitals exists statewide.[5]

REASONS FOR GRANTING THE WRIT

The State of New York based its claim for exemption from the DSA requirement, in the courts below, upon the special rule, 42 U.S.C. § 1396r-4(e), notwithstanding that the State Office of Mental Health does not make its DSH requests for federal funds under the special rule but rather, under the Boren Amendment and Act section 1923(b) and (d) (such requests would be unnecessary, if the special rule applied to the Office of Mental Health). Consequently, the petitioner is denied the funds for treating similarly situated low-income patients while the Office of Mental Health's request for its state-owned hospitals receipt of state and federal funds is accepted. Because the State's plan for psychiatric DSH hospitals is coincidental to the special rule *and* does not include a DSA for all hospitals meeting the statutory definition of a DSH (42 U.S.C. § 1396(b)(1), (d)), the State fails to meet the requirements of both section 1396a(a)(13)(A) and the special rule.

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[4] Public, or state-owned psychiatric hospitals are not covered under Article 28 of the state Public Health Law and, thus, cannot be included in the bad debt and charity pool.

[5] If Congress had intended to exclude a class or classes of hospitals from the DSA requirements of *Boren*, it would have done so explicitly. "Statewideness" could only refer to that class covered by the pooling arrangements (in this case, general hospitals), but not to extend to those statutorily qualified, but outside of the pooling arrangement.

Section 1396r-4(a) gave States until July 1, 1988 to implement the DSA requirement. New York did not meet that requirement and, since that date, it has been ineligible for the federal financial participation it has been receiving because the first requirement of section 1923(e) is that "(A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984. . . ." New York did not have a plan for disproportionate share hospitals as of January 1, 1984. What it had was something entirely different, a plan for charity and uncompensated care pools in general hospitals only, those hospitals subject to Article 28 of the New York Public Health Law. It had no plan, in 1984, for DSAs for private freestanding psychiatric hospitals either, or for state-owned hospitals for that matter.

Another decision of the New York Appellate Division - Third Department, correctly recognized that the purpose of the DSA is not to aid hospitals that experience losses from treating patients who are indigent or lack insurance. Instead, the court found that the legislative history of the underlying rationale for DSAs "more strongly indicated Congressional recognition that the regular ... rates of reimbursement are inadequate realistically to cover the higher direct and indirect costs of treating an indigent (and therefore less healthy) Medicare eligible population, a group having little if any connection with BDCC [bad debt and charity care] losses." *Arnot-Ogden Memorial Hosp. v. Axelrod,* 129 A.D. 2d 103, 108-109, 516 N.Y.S. 2d 972, 977 (3d Dep't 1987).

> That the disproportionate share provision addresses a cost problem different from that of the uncompensated hospital costs of treating indigent uninsured BDCC cases is made even more clear from the House Report on the proposed 1985 amendments to the same subsection [42 U.S.C. former § 1395ww(d)(5)(C)(i)], concededly inserted to further implement the purposes of that subsection: "Hospitals that serve a disproportionate share of low-income patients have higher medicare costs per case" (House Report [Ways and Means Committee], No. 99-241, July 31, 1985, *reprinted in* 1986 U.S. Code Cong. & Admin. News, pp. 42,594).

Id.

An earlier report by the House Ways and Means Committee explained the purpose of the adjustment: "Concern has been expressed that public hospitals *and other hospitals* that serve such [Medicare and low-income] patients may be more severely ill than average. . . ." H.R. Rep. 25, 98th Cong. 141-42 (1983), reprinted in 1983 U.S.C.C.A.N. 143,360-61 (emphasis added). Obviously, the same factors that result in higher costs for poor Medicare patients apply equally to the poor who are covered by Medicaid. Not only were New York's bad debt and charity care pools established to address a problem different from that identified by Congress in requiring the DSA, but the State admits that these pools were, and remain, available only to general hospitals regulated by the New York Department of Health.

In view of the foregoing, it is unsurprising that the State did not produce a plan for disproportionate share hospitals as of

January 1, 1984. RPHC emphasized this omission in the Appellate Division, noting that the State had the burden to establish the applicability of the exception on which it relied. *United States v. First City Nat'l Bank of Houston,* 386 U.S. 361, 366 (1967). The Appellate Division disagreed, stating erroneously that the Hospital's contention "lacks merit since petitioner had the burden of proof on the issue of compliance with the Medicaid laws" citing *Multicare Medical Ctr. v. Washington,* 768 F. Supp. 1349, 1389 (W.D. Wash. 1991). *Rye,* 630 N.Y.S. 2d at 595. However, the court's reference to *Multicare* was incorrect. In fact, *Multicare* states that the burden of proof shifts to the State on the substantive claims. *Multicare* at 1396. "Otherwise the Court and the plaintiffs are left with the task of doing what the State was required to do under federal law. . . ." *Id.* In addition, what *Multicare* emphasized was that

> The Medicaid Act, as modified by the Boren Amendment, has been the cause of significant litigation in many states. . . . The failure of Congress or the Secretary of Health and Human Services to define these critical terms has caused the States to expend millions of dollars in attempting to comply with these amorphous terms.

Id. at 1390. *See also Pinnacle Nursing Home v. Axelrod,* 928 F.2d 1306 (2d Cir. 1991), where the court held that the State had to show (and failed) that it made the "findings" required by law.

Although the Hospital's original claim in the district court on the illegal minimum utilization adjustment was decided on procedural grounds, its DSA claim was a substantive one which was delayed by that court pending a "cure" that the State never pursued. Paying a DSA is required whether there was a minimum utilization penalty, whether its cure was pursued, or not. Since the DSA is a *percentage* (5 percent for RPHC), even though the State was wrong in the amount of its reimbursement, it could still have obeyed the law by providing the 5 percent DSA to whatever base amount. Since the State had the burden of proof that it *had* the requisite plan in place in 1984 and, if it had, that the special rule "exemption" pertained to petitioner, it is difficult to imagine what more the Hospital could have done, or should have been required to do to substantiate the nonexistence of the required plan, or to prove that a statute that the respondent does not use for its psychiatric hospital "exemption" is inapplicable. Unfortunately, both state courts erroneously shifted the burden of that proof from the respondents to the petitioner.

The appellate court also irrelevantly noted that at the hearing the State established that the Department of Health and Human Services ("HHS") had

> approved its request for an exemption from the Boren Amendment's disproportionate share adjustment requirement based upon the respondents' assurance that payment of allowances to hospitals from the state's bad debt and charity pools met the requirements of the "special rule." The effect of this approval is that respondents do not have to include a disproportionate share adjustment in the rate paid to disproportionate share hospitals.

Rye, 630 N.Y.S. 2d at 595.

The special rule does not allow a state to be exempt from a DSA or its equivalent nor is there any statute or rule which gives HCFA discretion in deciding whether a State has met the requirements of the special rule. Plan amendments must be approved by HCFA which may be based upon no more than a State's assurances of compliance with the statutory requirements (42 C.F.R. § 447.253(a)). Since exemption from the requirements of the Boren Amendment was not within HCFA's power to grant, the States and the Appellate Division's reliance thereon is misplaced.

Appropriate application of the special rule only deems a State to have met the requirements of the Boren Amendment regarding implementation subsection (a) of 42 U.S.C. § 1396r-4. States must still make findings that Congress has a right to assume are correct. New York cannot decide that RPHC is not eligible for DSAs since the statute, 42 U.S.C. § 1396r-4(b) defines which hospitals are eligible. Since the special rule requires that the "aggregate amount of the payment adjustments *under the plan* for such hospitals [as are defined as DSHs] is not less than the aggregate amount of such adjustments otherwise required to be made under the [definition] subsection" (42 U.S.C. § 1396r-4(a)), exclusion of a class of hospitals violates the special rule's obvious intent. 42 U.S.C. § 1396r-4(e) (emphasis supplied). "Aggregates" cannot be taken as identical with "total number of dollars" in this connection, since different hospitals' cost centers vary, new hospitals are built and others close, constantly changing the total dollars the State spends for hospital reimbursement under Medicaid. Aggregate must mean only one thing for purposes of the special rule; that all hospitals which a state plan allowed to participate in its pool, would be the only ones whose "costs which must be incurred" that are *countable* in the aggregate. If that were not allowed to be the case, *Wilder*, and *Boren* as well, would be dead letters.

But here the State provided incorrect, ritualistic, unsupported assurances that "[t]he State of New York provided for payment adjustments for disproportionate share hospitals as of January 1, 1984 . . ."; that the state plan "complies with the disproportionate share requirements of § 1902(a)(13)(A) of the Social Security Act", a statement that was also incorrect, and is incorrect to this day, because the State has still provided no assurances regarding payments to hospitals which otherwise qualify for DSAs according to the law which are outside of the pool. Yet, this was the basis for HCFA's "approval." In view of the Secretary's long-standing, implacable, documented hostility to the DSA, such approval is suspect at best.

The host of decisions finding state plans that had been "approved" by HCFA to be in violation of the Medicaid statute demonstrates that HCFA approval offers no assurance, or even evidence, of the legal sufficiency of state plans. *E.g., Wilder,* 496 U.S. 498; *Pinnacle Nursing Home v. Axelrod,* 928 F.2d at 1314 ("we do not read the scope of our review as being limited to rubber stamping agency action"); *Kansas Health Care Ass'n v. Dep't of Social and Rehabilitation Srvs.,* 31 F.3d 1536 (10th Cir. 1994); *Illinois Health Care Ass'n v. Bradley,* 983 F.2d 1460 (7th Cir. 1993); *Arkansas Medical Soc'y, Inc. v. Reynolds,* 6 F.3d 519 (8th Cir. 1993); *Kansas Health Care Ass'n v. Dep't of Social and Rehabilitation Servs.,* 903 F. Supp. 1449, 1451-52 (D. Kansas 1995).

The unalterable fact remains that HCFA approved a state plan that did not provide for disproportionate share payment adjustments to anyone as of January 1, 1984 in contravention of the law. Thus, the New York plan did not qualify for the special rule and has been out of compliance with the Boren Amendment since July 1, 1988. The flexibility given by the Boren Amendment to the States is "to determine what methods and factors will produce rates adequate in fact given the circumstances particular to each State's hospitals." *Virginia Hosp. Assn. v. Baliles,* 868 F.2d 653, 659 (4th Cir. 1989).

Moreover, absent a DSA, a legally required component of a

Medicaid rate, the Medicaid rates paid to RPHC do not fall within the range of reasonableness doctrine, which requires rates adequate to pay hospitals which the State finds are efficiently and economically operated, pursuant to the Boren Amendment. In view of the heavy financial burdens Congress found would be placed on DSHs, it would be impossible for hospitals exceeding the threshold for DSAs, established by 42 U.S.C. § 1396r-4(b), to remain open for long. The very fact that the State has not made findings as to an "objective benchmark of an efficiently and economically operated facility" as directed by *Wilder* (*Wilder,* 496 U.S. at 519), is an indication the State must consider that the Hospital continues to fit the economically and efficiently operated requirements of *Boren,* an indispensable requirement for participation of a State under the Medicaid Act, and the basis of the DSA. For Congress to provide a financial percentage adjustment, recognizing the extra burden on hospital resources, and then permit the States to gut the underlying cost-basis defies reason. The State cannot, then, leave such a lawfully necessary component as a DSA out of the rate. *Multicare* held

> For purposes of determining whether the State's rates fall within the range of reasonableness, it is the entire reimbursement payment taken as a whole that is relevant, not the particular components that comprise the rate. *Folden* [*v. Washington State Dept. of Social and Health Services*] 744 F. Supp. [1507 (W.D. Wash. 1990)] at 1535 (citing *Colorado Health Care, 842 F.2d at 1167*).

Multicare, id. at 1397.

New York State has made no findings to support the withdrawal of plan amendment 88-30, either, and the suggestion by the HCFA Associate Regional Administrator that the State "may wish to withdraw" its amendments is unavailing and, for this reason the plan is out of compliance with the Medicaid Act. (Appendix 39a-40a). To arbitrarily sever the DSA puts the Hospital's reimbursement rate outside the range of reasonableness and, thus, outside of the law. *See Colorado Health Care Ass'n v. Colorado Dept. of Social Services*, 842 F.2d 1158, 1167 (10th Cir. 1988).

To say that *Boren* only requires the State to pay rates that are reasonable and adequate to reimburse efficiently and economically operated hospitals, and that such payment can be made at rates lower than the costs which "must be incurred" at those hospitals without making specific findings to support such departures from the statute is to mock Congress' attempt to see that the indigent receive proper care.

> In passing the Boren Amendment, Congress sought to decentralize the method for determining rates, but not to eliminate a State's fundamental obligation to pay reasonable rates. See S. Rep. No. 96-471, at 29 (flexibility given to States "not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care").

Wilder, 496 U.S. at 515.

The State has the right not to accept the will of Congress by refusing Medicaid funds, but is does not have the right to deny similarly situated patients of those providers with a beneficial interest in the Act ("Congress did not intend to foreclose a private judicial remedy under § 1983." *Wilder*, 496 U.S. at 523) from seeking appropriate reimbursement when treating higher-cost

Medicaid patients, in disproportionately large numbers, in States that participate in Medicaid.

The Denial of Equal Protection

As noted above, the State did not simply decide that the special rule exempted it from compliance with the DSA requirement of the Boren Amendment for general hospitals, it determined that it could also selectively obtain disproportionate-share funds for state-owned psychiatric hospitals, despite the alleged "exemption," while denying them to qualifying private psychiatric hospitals that meet the statutory definition. At the same time as the State relies on the special rule's alleged exemption from reporting according to the requirement of the DSA definition subsections of section 1396r-4, New York has, in fact, submitted its amendments to its state plan and received approval to obtain federal financial participation to only pay state-owned psychiatric DSAs.

As noted *supra*, the Hospital has asserted from the beginning that this State-sponsored scheme violates the Hospital's right to equal protection under the Fourteenth Amendment to the United States Constitution. The Appellate Division said:

> It is undisputed that allowances from the State's bad debt and charity pools are made to major public hospitals, as well as voluntary and private proprietary hospitals, but are not made to private psychiatric hospitals. Petitioner maintains that this violates its equal protection rights.

Rye, 630 N.Y.S. 2d at 596.

This is wrong on several counts. First, RPHC actually maintained that, assuming that the existence of the bad debt and charity pools somehow met the State's DSA obligation for the hospitals covered by the pools, there is still no rational basis for its exclusion of private, freestanding psychiatric hospitals from *both* the pools and the DSA, leaving the public psychiatric hospitals (which also do not participate in the pools) to receive DSAs. The hearing court then reasoned inappositely that there is a rational basis for excluding these hospitals from the pools because (a) the purpose of providing the allowances to general hospitals "is to cushion the financial losses they sustain from bad debts and the costs of charity care" (*Id.*), and (b), since private psychiatric hospitals generally "have a relatively low percentage of uncompensated care patients and are profitable enterprises . . . we find that there is a rational basis for excluding private psychiatric hospitals from receiving allowances from the subject pools. Thus, we reject petitioner's equal protection agreement." (*Id.*).

It is apparent from the foregoing that the court never considered the Hospital's contention; that the plan provision granting the DSA to public psychiatric hospitals and not to those that are private, regardless of their qualification under federal law, is irrational and unjustified under the Medicaid Act. For present purposes RPHC accepts the analysis of the Appellate Division with respect to the bad debt and charity pools. It never has questioned, on equal protection or any other grounds, the State statute under which such pools operate. New York Public Health Law § 2807 *et seq.* But as we have already shown, those pools are irrelevant to the requirement of a DSA. Their relevance is only to the requirement that the pool aggregates amount to the equivalent of DSAs for the hospitals that participate in them. As the Appellate Division correctly noted the pools were developed to "cushion the financial losses" general hospitals sustain from bad debts and the costs of charity care. *Id.* The *Boren*-based DSA, on the other hand, was to cushion all hospitals which serve a *disproportionately* large number of low income patients. The DSA provides an actuarial, congressionally determined adjustment to compensate for the costs of treating large numbers of indigent patients because they are sicker. It has nothing to do with charity care to, or losses from bad debts caused by, individual patients (theoretically, as few as one).

It follows necessarily that the "rational basis" found by the Appellate Division for the exclusion of private psychiatric hospitals from the pools provides no justification for RPHC's exclusion from the DSA. RPHC is a hospital that has had for years a Medicaid population more than double the minimum required to establish it as a DSH. Since the statute (42 U.S.C. § 1396r-4(b)(1)) defines a DSH, to which the DSA must be paid, it is unnecessary for a State to do so. It is also irrelevant that private psychiatric hospitals generally have a lower percentage of uncompensated care *relative* to state-owned hospitals or that they may be profitable enterprises. First of all, the Medicaid payment methodologies require payment based on costs, not on revenue; second, that statute does not differentiate between classes or kinds of eligible hospitals; and third, there is nothing in the statutory definition relating to profitability or uncompensated care.

The States were not given the power to engraft upon the law additional or different requirements. Rather, eligibility for the DSA is determined by a "medicaid inpatient utilization rate," defined in 42 U.S.C. § 1396r-4(b)(2), or a "low-income utilization rate," defined in 42 U.S.C. § 1396r-4(b)(3). A state plan must provide the DSA to any hospital public or private, meeting these definitions. Moreover, an agency of the State denies equal protection when it treats persons similarly situated differently under the law. *F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412 (1920). In the absence of either a suspect classification or infringement of a fundamental interest there must be a valid reason for differentiating among members of the same class. As this Court has stated, the test for a denial of equal protection under state law is "whether the challenged classification rests on grounds wholly irrelevant to the achievement of valid state objective." *Turner v. Fouche*, 396 U.S. 346 (1970).

Under this analysis the State must at least show a rational basis for its classification based on its discriminatory use of federal funds exclusively for state-owned and operated hospitals and the legitimacy of the governmental objective supposedly advanced by such exclusionary classification. The classification must then be compared to the objective to determine whether the classification rests on some ground having a fair and substantial relation to the object for which it is proposed. *New Orleans v. Dukes*, 427 U.S. 297, 303 (1976); *Reed v. Reed*, 404 U.S. 71, 76 (1971); *F.S. Royster*, 253 U.S. at 415.

The arbitrary character of the State's classification becomes apparent when this test is applied. Undoubtedly, a State has a legitimate interest in providing financial relief to general hospitals for the costs of bad debts and charity care. Perhaps, as the Appellate Division said, there is a rational basis for limiting such relief to general hospitals. But the DSA is a federal, not a state, mandate which is unconnected to bad debts and charity care needs of hospitals.

Accordingly, there is no rational basis for the unequal treatment distinction made by New York State, to take, solely for its own hospitals, that which federal law requires to be paid to all hospitals who qualify, and to deny state and federal funds to qualifying others on the basis of a "special rule," or anything else.

CONCLUSION

For the reasons stated in the foregoing, petitioner respectfully submits that the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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Attorney for Petitioner
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APPENDIX A — ORDER OF THE NEW YORK COURT OF APPEALS DENYING PERMISSION TO APPEAL DATED DECEMBER 7, 1995

State of New York,
Court of Appeals

At a session of the court, held at
Court of Appeals Hall in the
City of Albanyon the seventh
day of December 1995

PRESENT, HON. JUDITH S. KAYE, *Chief Judge, presiding.*

3-14 Mo. No. 1321

In the Matter of Rye Psychiatric Hospital Center, Inc.,

Appellant,

v.

Richard C. Surles, as Commissioner of the Office of Mental Health of the State of New York, et al.,

Respondents.

A motion for leave to appeal to the Court of Appeals in the above cause having heretofore been made upon the part of the appellant herein and papers having been submitted thereon and due deliberation having been thereupon had, it is

ORDERED, that the said motion be and the same hereby is denied.

s/ Donald M. Sheraw
Donald M. Sheraw
Clerk of the Court

APPENDIX B — OPINION AND ORDER OF THE APPELLATE DIVISION DATED AUGUST 3, 1995

In the Matter of RYE PSYCHIATRIC HOSPITAL CENTER INC., Appellant-Respondent,

v.

Richard C. SURLES, as Commissioner of the Office of Mental Health of the State of New York, et al., Respondents-Appellants.

Supreme Court, Appellate Division,
Third Department.

Aug. 3, 1995.

* * *

Frederick A. Nicoll, New York City, for appellant-respondent.

Dennis C. Vacco, Atty. Gen. (Vincent Leong, of counsel), New York City, for respondents-appellants.

Before CARDONA, P.J., and MERCURE, WHITE, PETERS and SPAIN, JJ.

WHITE, Justice.

Cross appeals from a judgment of the Supreme Court (Kahn, J.), entered November 5, 1993 in Albany County, which partially dismissed petitioner's application, in a proceeding pursuant to CPLR article 78, seeking, inter alia, Medicaid relief based on petitioner's status as a disproportionate share hospital.

Petitioner is a private psychiatric hospital located in the City of Rye, Westchester County, which participates in the Federal/State Medicaid program (42 U.S.C. § 1396 et seq.). To qualify for Federal reimbursement, a state must submit to the Secretary of the Department of Health and Human Services (hereinafter Department) for approval a plan which, inter alia, establishes a method for reimbursing health care providers (42 U.S.C. § 1396a[b]). Under the Boren Amendment, the state plan must provide for the payment of hospital services through the use of rates which the state finds, and make assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities (42 U.S.C. § 1396a[a][13][A]). In formulating its plan, the state must take into account, inter alia, the situation of hospitals which serve a disproportionate number of low-income patients with special needs by providing an appropriate increase, known as a disproportionate share adjustment, in the rate paid to disproportionate share hospitals for inpatient hospital services provided to low-income patients (42 U.S.C. § 1396a[a][13][A]; § 1396r-4[a][1][B]).

In response to the Boren Amendment, the State Office of Mental Health, the agency responsible for setting the reimbursement rates for private psychiatric hospitals, adopted a reimbursement schedule that included a "minimum utilization adjustment" (14 NYCRR former 577.7[g]). The effect of this adjustment was to decrease the per diem reimbursement rate for hospitals operating at less than 75 percent capacity. Petitioner successfully challenged this adjustment in a Federal court action (see, Rye Psychiatric Hosp. Ctr. v. Surles, 768 F.Supp. 82, 89).

Thereafter, petitioner commenced this CPLR article 78 proceeding seeking a judgment directing respondents to discontinue the use of the minimum utilization adjustment and to recalculate its rates to include a disproportionate share adjustment. Ultimately, petitioner secured a judgment in August 1992, directing respondents to recalculate its rate for the 1986 through 1991 rate years without the use of the minimum utilization adjustment. The issue of petitioner's entitlement to a disproportionate share adjustment was referred for a hearing, following which Supreme Court found that petitioner was not entitled to a disproportionate share adjustment but was entitled to interest on the reimbursement due it as the result of the recalculation of its 1986 through 1991 rates. These cross appeals ensued.

A "special rule" permits a state Medicaid plan to be considered in conformance with the Boren Amendment if payment adjustments for disproportionate share hospitals were provided to a majority of hospitals as of January 1, 1984 and if the aggregate amount of such payments is not less than would be required under the Boren Amendment (42 U.S.C. § 1396r-4[e][1][i], [ii]). At the hearing, respondents established that the Department approved its request for an exemption from the Boren Amendment's disproportionate share adjustment requirement based upon respondents' assurance that payment of allowances to hospitals from the State's bad debt and charity pools met the requirements of the "special rule". The effect of this approval is that respondents do not have to include a disproportionate share adjustment in the rate paid to disproportionate share hospitals.

Petitioner contends that Supreme Court erred in concluding that the State met the requirements of the "special rule" since respondents offered no proof on this issue. This contention lacks merit since petitioner had the burden of proof on the issue of compliance with the Medicaid laws (see, Multicare Medical Ctr. v. Washington, 768 F.Supp. 1349, 1389). We further note that, unlike the Boren Amendment, there is no language in 42 U.S.C. § 1396r-4(e) requiring a state to make findings supporting its request for an exemption under the "special rule" (compare, Wilder v. Virginia Hosp. Assn., 496 U.S. 498, 505-509, 110 S.Ct. 2510, 2515-2517, 110 L.Ed.2d 455). Moreover, a state's request under the "special rule" does not implicate the Boren Amendment's requirement for findings since such request does not involve a change in payment method or standards (see, 42 CFR 447.253[b]). Therefore, for these reasons and as it is presumed that respondents acted in accordance with the law (see, Richardson, Evidence § 72, at 49 [Prince 10th ed]; Fisch, NY Evidence § 1134, at 649 [2d ed]), we conclude that Supreme Court's finding that the State has an exemption under the "special rule" from the Boren Amendment's disproportionate share adjustment requirement is correct.

It is undisputed that allowances from the State's bad debt and charity pools are made to major public hospitals, as well as voluntary and private proprietary hospitals, but are not made to private psychiatric hospitals. Petitioner maintains that this violates its equal protection rights.

A classification will survive an equal protection challenge so long as it is based upon some ground of difference having a fair and substantial relation to a reasonable and identifiable governmental objective (see, Greenstein v. Bane, 833 F.Supp. 1054, 1075). Also, government regulation in the area of economics and social welfare "carries with it a presumption of rationality that can only be overcome by a clear showing of arbitrariness and irrationality" (Hodel v. Indiana, 452 U.S. 314, 331-332, 101 S.Ct. 2376, 23862387, 69 L.Ed.2d 40).

The purpose for providing allowances to general hospitals from the bad debt and charity pools is to cushion the financial losses they sustain from bad debts and the costs of charity care (see, Public Health Law § 2807-c[14] [b]). Inasmuch as the record evidence shows that private psychiatric hospitals have a relatively low percentage of uncompensated care patients and are profitable enterprises, and as petitioner offered no proof on this issue, we find that there is a rational basis for excluding private psychiatric hospitals from receiving allowances from the subject pools. Thus, we reject petitioner's equal protection argument.

We shall reverse Supreme Court's award of interest in light of our consistent holdings that there is no statutory authority, express or implied, for such an award under these circumstances (see, Matter of New York State Health Facilities v. Axelrod, 199 A.D.2d 752, 754, 605 N.Y.S.2d 497. revd. on other grounds 85 N.Y.2d 326, 332, 624 N.Y.S.2d 563, 648 N.E.2d 1326; Matter of Trustees of Masonic Hall & Asylum Fund v. Commissioner of New York State Dept. of Health, 193 A.D.2d 249, 603 N.Y.S.2d 587, appeal dismissed 83 N.Y.2d 802, 611 N.Y.S.2d 137. 633 N.E.2d 492; Demisay v. Whalen, 84 A.D.2d 902 444 N.Y.S.2d 776). On this point, we note that while the Federal regulation requires the payment of providers' claims within 12 months, it further states that this time limitation does not apply to payments made in accordance with a court order, which it states can be made at any time (42 CFR 447.45[d][4][iv]). Had the payment of interest been contemplated under such circumstances, it can be presumed that the regulation would have so provided (see, Matter of National Farmers Org. v. Gerace, 66 N.Y.2d 719, 722, 496 N.Y.S.2d 993, 487 N.E.2d 903).

ORDERED that the judgment is modified, on the law, without costs, by reversing so much thereof as awarded interest, and, as so modified, affirmed.

CARDONA, P.J., and MERCURE, PETERS and SPAIN, JJ., concur.

APPENDIX C — ORDER AND JUDGMENT OF THE SUPREME COURT OF NEW YORK FOR THE COUNTY OF ALBANY ENTERED NOVEMBER 5, 1993

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

Index No. 5174/90

RJI NO. 0190 ST2696

APPLICATION OF RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Petitioner,

-against-

RICHARD C. SURLES, Ph.D., Commissioner of The Office of Mental Health of The State of New York, and MARY JO BANE, Commissioner of The State of New York, Department of Social Services,

Respondents.

ORDER AND JUDGMENT

JUSTICE LAWRENCE E. KAHN

The issues in this proceeding pursuant to CPLR Article 78 having come on to be heard on April 10, 1992 at a Term of the Supreme Court, County of Albany at the Court having rendered its decision dated July 17, 1992 in favor of Petitioner and referring for a hearing the issue of disproportionate share payments and judgment thereon having been entered on August 19, 1992 and a hearing on this issue and on the payment of interest on the amounts payable under the prior judgment having been held on February 25, 1993 at a Term of the Supreme Court, Albany County at the Courthouse, Albany, New York, before the Hon. Lawrence E. Kahn. Petitioner appeared by Frederick A. Nicoll, Esq. of Shanley & Fisher, and Respondents appeared by Brian T. McGovern Esq. of the New York State Department of Law, and the Court having rendered its decision dated June 10, 1993, in favor of Respondent on another issue and directing the entry of judgment as stated, and the costs and disbursements of Petitioner having been taxed in the sum of $*945.00*.

NOW, on motion of Shanley & Fisher, attorneys for Petitioner, it is

ADJUDGED

That this application is granted to the extent that Respondents are Ordered to calculate and pay interest to Petitioner from July 17, 1992 on the amount payable pursuant to the decision of that date to the dates of payment at the rate of 9 percent per annum within 60 days of service of this Order and Judgment. In all other respects, except as granted by the judgment entered August 19, 1992, the Petition is denied.

s/ Lawrence E. Kahn
Hon. Lawrence E. Kahn, J.S.C.
10/18/93

Entered this 5 day of November, 1993

Clerk

APPENDIX D — OPINION OF THE SUPREME COURT OF NEW YORK FOR THE COUNTY OF ALBANY DATED JUNE 10, 1993

STATE OF NEW YORK
SUPREME COURT
COUNTY OF ALBANY

APPLICATION OF RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Petitioner,

For a Judgment pursuant to Article 78 of the CPLR

-against

RICHARD C. SURLES, PhD., Commissioner of the Office of Mental Health of the State of New York, and GREGORY KALADJIAN, Acting Commissioner of the State of New York, Department of Social Services,

Respondents.

Supreme Court - Request for Judicial Intervention
Trial-February 25, 1993
RJI 0190 ST2696
Index No. 5174/90

JUSTICE LAWRENCE E. KAHN, Presiding

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KAHN, J.

Petitioner, Rye Psychiatric Hospital Center, Inc. (Rye), is a private psychiatric hospital, which seeks a judgment declaring that it serves a disproportionate number of low-income patients with special needs and is therefore entitled to an additional Medicaid reimbursement of five percent retroactive from January 1, 1986. Respondent objects on the grounds that the State of New York is not required to pay disproportionate-share adjustments because the federal government has granted it a "special rule" exemption. Rye further seeks to compel respondents to pay post-decision and post-judgment interest due on an earlier judgment.

Medicaid is a joint federal and state program which provides financial assistance for needy individuals. (42 U.S.C., section 1396). In order to grant the states more flexibility in fashioning their own Medicaid plans, Congress adopted the Boren Amendment to the Social Security Act in 1981. (42 U.S.C., section 1396(a)(13)[A]). In New York State, the program is splintered among various parts of the bureaucracy. The Department of Social Services (DSS) oversees administration of the Medicaid program. The Department of Health (DOH) establishes the rates of Medicaid reimbursement for general hospitals and the Office of Mental Health (OMH) sets reimbursement rates for private psychiatric hospitals.

Under the Boren Amendment, a participating state is required to reimburse the health care provider at rates "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . ." (42 U.S.C., section 1396(a)(13)[A]). Such methods must "take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs . . . ." (section 1396r-4. Id.). Rye claims that as a disproportionate share hospital, it is entitled to an additional reimbursement of five percent under the applicable federal formula.

In 1984, as part of its reimbursement plan, OMH adopted a minimum utilization rate, which provides that if a private psychiatric hospital did not achieve an overall occupancy rate of at least 75% each year, a fictitious number of "patient days" would be imputed to the hospital to reach that level. Because petitioner operated at below 75% of capacity, this resulted in a substantially reduced reimbursement. In 1988, petitioner successfully argued in Federal Court that this formula violated the Boren Amendment. The court found the minimum utilization factor regulation null and void. (***Rye Psychiatric Hosp. Center, Inc. v. Surles***, 768 F. Supp. 82 [S.D.N.Y. 1991]), and ordered the State to comply with its opinion of July 2, 1991 from that date forward.

Petitioner then brought this Article 78 proceeding to recover underpayment from 1986 through July 2, 1991. In an opinion dated July 17, 1992, The Honorable George L. Cobb directed respondents to recompute Rye's rate for those years without application of the minimum utilization factor and to pay that amount within sixty days. However, he found a question of fact upon the issue of whether Rye was entitled to a disproportionate share adjustment and ordered a hearing with respect thereto. Judgment was entered on August 21, 1992. These dates are important for resolution of the subsequent issue of interest payments due. Rye was paid the judgment amount in two installments. However, the State did not include interest on the judgment with those payments pursuant to CPLR 5002 and 5003; this issue will be discussed in further detail below. Pursuant to Judge Cobb's decision, this court conducted the required hearing and renders this decision with respect thereto.

The state has a special rule exemption which allows it to meet the requirement of payment adjustments to its disproportionate-share hospitals. 42 U.S.C., section 1396r-4(e) provides that a state's plan meets the requirement if

> "(A) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984 . . . . , and (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection."

New York State does exercise such a pooling arrangement involving general hospitals; this arrangement provides aid to hospitals serving those unable or unwilling to pay for medical services. In 1989 the Federal Health Care Financial Administration (HCFA) concluded that New York satisfied the requirements of the special rule through use of this pooling arrangement. And although private psychiatric hospitals are not included in the pooling arrangement, this does not necessarily mean that Rye is entitled to the reimbursement it now seeks.

In reviewing the pooling arrangement, the court must determine whether there was a rational basis to support the agency's findings; in doing so, the standard of review is "highly deferential" and the agency action is presumed to be valid if a "reasonable basis" exists for its decision. *Id.* at 800, citing ***California Hosp. Ass'n v Schweiker***, (559 F. Supp. 110, 116 [1982]). Therefore, the agency decision should only be disturbed if it can be shown that the action was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." (***Pinnacle Nursing Home v Axelrod***, 928 F.2d 1552 [11th Cir., 1986]).

In the case at hand, it is clear that the agency decision was not "capricious"; rather, it was based on review of all the statutory factors. There is a rational basis for the exclusion of private psychiatric hospitals from the bad debt and charity pooling arrangement. The very nature of public hospitals precludes them from turning patients away and as such, they remain uncompensated for care of the indigent and uninsured. The disproportionate-share payment adjustments serve to reduce this deficit. On the other hand, private psychiatric hospitals are able to turn away patients based on inability to pay and therefore, are reimbursed for 100% of their Medicaid expenses. For these reasons, many, such as Rye, operate at a profit. As such, petitioner's equal protection claims must be dismissed. Merely because a classification "is not made with mathematical nicety or because in practice it results in some inequality", the Equal Protection Clause is not invoked so long as there is some "reasonable basis" for the classification. (***Pinnacle Nursing Home v Axelrod***, 928 F.2d 1306 (2nd Cir., 1991), citing ***Lindsley v National Carbonic Gas Co***., 220 U.S. 61 [1991]). Because of petitioner's status as a private psychiatric hospital, generally operating at a profit, they do not have the same financial considerations as general hospitals treating indigent and uninsured patients. Accordingly, denial of petitioner's request for an additional five percent reimbursement adjustment should not be disturbed.

In the second issue in the case, petitioner seeks to compel respondents to pay post-decision interest pursuant to CPLR 5002 and post-judgment interest pursuant to CPLR 5003. This issue arises as a result of the federal court decision in ***Rye Psychiatric Hospital Center, Inc. v Surles***, (768 F. Supp. 82 [S.D.N.Y. 1991]), which declared null and void the "minimum utilization factor" set forth in 14 NYCRR, section 577.7(g).

Respondents paid petitioner in two installments; however, the amount paid did not include any interest on the judgment for the periods between the date of the decision and the entry of the judgment and from the entry of the judgment until satisfaction, as is mandated by CPLR 5002 and 5003. According to petitioner's Calculation, this amounts to 536,756.94 at the rate of nine percent interest prescribed in CPLR 5004.

The obligation to pay interest on a judgment arises out of CPLR 5001, 5002 and 5003. CPLR 5002 provides that "interest should be received upon the total sum awarded . . . from the date the verdict was rendered or the report or decision was made to the date of entry of final judgment." Similarly, section 5003 mandates that "every money judgment shall bear interest from the date of its entry. Every order directing the payment of money which has been docketed as a judgment shall bear interest from the date of such docketing." Once a money judgment is entered, the obligation of the party against whom the judgment is entered is mandatory, not discretionary. The purpose of such an interest award is to indemnify the successful plaintiff for the defendant's wrongful use of his money; it is presumed that during the time the defendant held such money, they had use it for their benefit and realized some profit from its use. Therefore, to allow the defendant to retain the cost of using money (the interest) would provide the defendant with an unfair windfall. (*Love v State of New York*, 78 N.Y.2d 540 at 545, 577 N.Y.S.2d 359, 583 N.E.2d 1296 [1991]).

Respondent argues that the question of interest is not invoked by this judgment because the decision and judgment did not direct respondents to pay petitioner a sum of money; rather, they only direct respondents to recompute petitioner's rates of Medicaid reimbursement. However, this does not relieve respondents of their obligation to pay interest; rather, interest attaches uniformly to all money obligations reduced to verdict or judgment, **"including money awards *incidental to*** equitable relief." (Siegel, Practice Commentary CPLR 5001:1 [emphasis added]). This result is reflected in the definition of "money judgment" in CPLR 105(q), which defines it as "a judgment, or any part thereof, for a sum of money or directing the payment of a sum of money" (emphasis added). Clearly, this encompasses the judgment in the case at hand which directed respondent to pay petitioner the back amount due. That an order to pay money is incidental to equitable relief does not alter the fact that petitioner is being deprived of money due and owing to him while a judgment remains unsatisfied. (***Love***, 78 N.Y.2d at 545).

Interest accrues on the date that a verdict or decision is entered and continues to accrue until the judgment is fully satisfied. (***Feldman v Brodsky***, 12 AD2d 347 [First Department, 1961]; ***Grossman v Fieland***, 107 AD2d 659 [Second Department, 1985]). When Judge Cobb directed respondents to recompute the amount due to petitioners and to make such payments, that amount included interest due. The State is not immune from the obligation to make such interest payments. The same analysis applies for the post-judgment interest due under CPLR 5003.

All papers are being returned to attorneys for petitioner, who shall settle an order and judgment on notice, in conformance herewith, with a copy of this decision annexed.

DATED: June 10, 1993
Albany, New York

APPENDIX E — DECISION OF THE SUPREME COURT OF NEW YORK FOR THE COUNTY OF ALBANY DATED JULY 17, 1992

STATE OF NEW YORK
SUPREME COURT
COUNTY OF ALBANY

(Supreme Court, Albany County Special Term,
April 10, 1992. RJI 01-90-ST2696, Calendar #3)

Application of RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Petitioner,

For a judgment pursuant to Article 78 of the CPLR

-against-

RICHARD C. SURLES, PhD., Commissioner of the Office of Mental Health of the State of New York, and GREGORY KALADJIAN, Acting Commissioner of the State of New York Department of Social Services,

Respondents.

(JUSTICE GEORGE L. COBB PRESIDING)

APPEARANCES: Shanley & Fisher (Frederick A. Nicoll of counsel), for petitioner.

Robert Abrams, Attorney-General (Brian T. McGovern of counsel), for respondents.

COBB, J.

Petitioner has commenced an article 78 proceeding seeking to recover underpayments in medicaid reimbursements based upon a Federal Court's determination that the minimum utilization factor provided for in 14 NYCRR 577.7 (g) was null and void (Rye Psychiatric Hosp. Cent. v. Surles, 768 F. Supp. 82). Petitioner also seeks a determination that it is entitled to additional compensation on the ground that it is a disproportionate share hospital, prejudgment interest and an award of attorneys' fees.

The federal court held that the New York State regulation imposing a minimum utilization factor which substantially reduced petitioner's medicaid reimbursement rate was null and void based upon procedural defects in the state's submission of its medicaid plan to the Federal government. While the Office of Mental Health intends to seek permission to correct such procedural defects nunc pro tunc, thereby allowing respondent to maintain an effective date of the regulation of 1984, it appears unlikely that such relief will be granted. Moreover, respondent Office of Mental Health has not even submitted any such request to the Federal government at this time. As such, the status of the regulation as being null and void is final and binding upon respondents. While the regulation could conceivably be revitalized, the current status is substantially equivalent to a judgment which is under appeal and which is still granted full collateral estoppel effect.

Accordingly, the petition is hereby granted to the extent that respondents are directed to recompute petitioner's reimbursement rats for the years 1986 through 1991 without the reduction imposed by the minimum utilization factor.

Respondents are directed to make such recomputation and pay such sums as they are due and owing to petitioner within 60 days of service of the judgment to be entered hereon. Given the fact that it is possible that the minimum utilization factor regulation will be revitalized effective as of 1984, all such payments shall be conditioned upon respondents' right to recoup such payments in the event the effective date is prior to 1986.

Petitioner also seeks an additional 5% payment on the ground that petitioner constitutes a disproportionate share hospital obtaining more than 25% of its operating revenues from low income clients. The Court is unable to ascertain from the submissions of the parties whether medicare payments for qualified medicare beneficiaries are made at the same rate as medicaid payments. If they are, such payments should be included in the computation of low income utilization since the additional 5% payment is intended to help make up for lower medicaid payments as compared to payments by higher income patients and clients. However, if medicare payments for qualified medicare beneficiaries are at a higher rate than medicaid payments, the mere fact that they benefit low income persons is an insufficient ground to include them in the low income utilization computation. In addition, the state has failed to provide any evidence that the exemption from the disproportionate share hospital provisions is in fact applied statewide, including private psychiatric and specialty hospitals or that there are any pooling arrangements in effect. Accordingly, a hearing shall be required on the issue of whether petitioner is entitled to the additional 5% compensation based on its status as a disproportionate share hospital.

Since it has been determined that petitioner's claims are not in the nature of contractual obligations (Matter of Rye

Psychiatric Hosp. Cent. v. State of N.Y., __AD2d__, 576 NYS2d 449), petitioner's application for prejudgment interest shall be denied. It appears that petitioner is entitled to an award of attorneys' fees in the instant action under Federal law. The sole basis for the instant action is the determination of petitioner's Federal action brought pursuant to 42 USC 1983. While petitioner was unable to enforce its 1983 claim with respect to prior years based upon jurisdictional limitations of the Federal Court, the instant action in effect serves to enforce the 1983 claim. Petitioner has not submitted any evidence with respect to the amount of an award for attorneys' fees and it appears that a hearing on such issue is warranted. Accordingly, such issue shall be joined with the issue with respect to petitioner's status as a disproportionate share hospital. In addition, the award of attorneys' fees shall be subject to recoupment in the event the minimum utilization factor is granted retroactive status by the Federal government since petitioner will not have prevailed in the instant proceeding in such event. Petitioner is directed to file a trial term note of issue with the Albany County Supreme Court Clerk.

Submit judgment on notice.

Dated: July 17, 1992

All papers to attorneys for petitioner.

Papers submitted:

Notice of amended petition dated February 10, 1992; amended petition verified February 7, 1992; exhibits A&B.

Affidavit of Thomas A. Luisi sworn to on March 6, 1992; exhibit.

Appendix E

Affidavit of Ivars Semeiks sworn to on March 25, 1992; exhibits A&B.

Answer dated April 2, 1992.

Affidavit of Frederick A. Nicoll sworn to on April 8, 1992; exhibits A-C.

Affidavit of Brian T. McGovern sworn to on April 10, 1992; exhibits A&B.

APPENDIX F — PAGES 243-251, 255 OF THE RECORD ON APPEAL

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

DAVID EMIL
Deputy Commissioner
and General Counsel

CESAR A. PERALES
Commissioner

June 30, 1988

Mr. Arthur J. O'Leary
Mr. Theodore J. Shulman
Associate Regional Administrators
Health Care Financing Administration
Department of Health and Human Services
Region II - Room 3800
26 Federal Plaza
New York, New York 10278

Dear Messrs. O'Leary and Shulman:

Enclosed for your approval is submittal 88-30 which is an amendment to this Department's State Plan under Title XIX of the Social Security Act (Medical Assistance).

This amendment reflects in Attachment 4.19-A, Part III of the Plan certain revisions to the Office of Mental Health's (OMH) reimbursement methodology for private psychiatric hospitals to comply with the Federal requirements regarding payment to disproportionate share hospitals.

Appendix F

Your regulations at 42 CFR 447.252 and 255 require state agencies to submit various assurances and related information when making changes in payment methods and standards. Enclosed is a letter dated June 20, 1988 from Ivars Semieks, Assistant Director, Finance Group, which forwarded the requisite assurances and related information to this Department. Therefore, the requisite assurances and related information are being submitted under separate cover to William Toby, Administrator of your Department.

In keeping with our continuing agreement, although this amendment will be mailed to you by June 30, 1988, the effective date of this amendment will be July 1, 1988, which is the effective date requested by OMH.

Please contact Linda Odeen of my staff at (518) 474-7695 if you have any questions regarding this amendment.

Very truly yours,

s/ Anne E. Grace
Deputy Counsel

Enclosures
illegible
2/25/93

Appendix F

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

CESAR A. PERALES
Commissioner

June 30, 1988

Dear Mr. Toby:

In order for this Department, as the single State agency for Medical Assistance, to meet the requirements of Title XIX of the Social Security Act relating to the State assurances and additionally related information required to be provided to the Health Care Financing Administration pursuant to Section 1902(a) of the Social Security Act (42 USC §1396a(a)(13B)) and Title 42 of the Code of Federal Regulations, Part 447, Subpart C, the Office of Mental Health (OMH) has made the required assurances and has provided the related information. The Department has accepted these assurances and related information.

Therefore, this Department, as the single State agency, assures, finds, and determines as follows:

I. *Assurances*

(1) In accordance with the provisions of 42 CFR §447.253(b)(1)(i), rates of payment established by OMH for inpatient hospital services furnished by hospitals operated by OMH are reasonable and adequate to meet the costs that must be incurred by

efficiently and economically operated providers to provide services in conformity with applicable State and federal laws, regulations, quality and safety standards.

(2) In accordance with the provisions of 42 CFR §447.253(b)(ii)(A), the methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs.

(3) In accordance with the provisions of 42 CFR §447.253(b)(1)(ii)(B), the methods and standards used to determine payment rates provide that reimbursement for hospital patients receiving services at an inappropriate level of care under conditions similar to those described in §1861(v)(1)(G) of the Social Security Act will be made at lower rates, reflecting the level of care actually received, in a manner consistent with §1861(v)(1)(G).

(4) In accordance with the provisions of 42 CFR §447.253(b)(1)(ii)(c), the payment rates established by OMH are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(5) In accordance with the provisions of 42 CFR §447.253(b)(2), the estimated average proposed

payment rates are reasonably expected to result in aggregate payments for inpatient hospital services that will not be more than the amount OMH reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

Additionally, OMH assures that:

(a) OMH provides an appeal or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate of payment rates.

(b) OMH provides for the filing of uniform cost reports by participating providers.

(c) OMH provides for periodic audits of financial and statistical records of participating providers.

(d) OMH provides that it complies with the public notice requirements in §447.205.

(e) OMH provides that the rates of payments are established in accordance with the methods and standards specified in our approved State Plan.

(f) OMH provides that it complies with the provisions of federal Medicaid law

Appendix F

§1902(a)(13) of the Social Security Act, as amended by §2314 of the Medicare and Medicaid Budget Reconciliation Amendments of 1984, with regard to limiting Medicaid reimbursement for costs associated with the sale or transfer of a hospital.

In accordance with the provisions of 42 CFR §447.255, OMH submits the following related information:

(1) The amount of the average proposed payment rate weighted by total days used in the calculation of the rate for inpatient hospital services provided by Private Psychiatric Hospitals is not expected to change as a result of the proposed changes to the Medicaid State Plan. Currently, no Private Psychiatric Hospital receives an add-on for qualifying as a disproportionate share hospital. Under the new rules being processed, it appears that this will continue to be true.

(2) The change in the estimated average payment rate is expected to have no effect on the availability of services on a statewide and geographic area basis.

(3) Such change is expected to have no effect on the type of care furnished.

(4) Such change is expected to have no effect on the extent of provider participation.

(5) Such change is expected to have no effect on the degree to which costs are covered in hospitals that

serve a disproportionate number of low-income patients with special needs.

I believe the assurances and related information provided by this letter will be adequate to enable your Department to determine that this Department complies with the pertinent requirements of §1902(a) of the Social Security Act (42 USC §1396a(a)(13B)) and 42 CFR, Part 447, Subpart C and to approve Title XIX State Plan submittal 88-30.

If you have any questions regarding this matter, please do not hesitate to contact David Emil, Deputy Commissioner and General Counsel, at (518) 474-9502.

Sincerely,

s/ Cesar A. Perales
Cesar A. Perales
Commissioner

Mr. William Toby
Regional Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
Region II - Room 3800
26 Federal Plaza
New York, New York 10278

cc: Arthur J. O'Leary
Theodore J. Shulman

Appendix F

METHODS AND STANDARDS OF SETTING PAYMENT RATES FOR HOSPITALS LICENSED BY THE OFFICE OF MENTAL HEALTH

In accordance with the New York State Mental Hygiene Law, the State's Office of Mental Health establishes Medicaid rates of reimbursement for hospitals issued operating certificates by the Office of Mental Health. The class of facilities defined as hospitals includes the subclass of Residential Treatment Facilities for Children and Youth ("RTFs") which furnish inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs. Medicaid rates established by the Office of Mental Health must be certified by the Commissioner and approved by the Director of the Budget. The Methods and Standards set forth below do not apply to hospitals operated by the Office of Mental Health or to hospitals licensed by the Department of Health.

A. HOSPITALS OTHER THAN RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND YOUTH

1. OPERATING COSTS

Medicaid rates are established prospectively and are all inclusive, taking into account all allowable patient days and all allowable costs. Effective January 1, 1985, allowable patient days are computed on the basis of the greater of actual days or a minimum utilization factor of 75%. Medicaid rates are effective for a twelve month period conterminous with the hospital's fiscal year. Payment rates for a rate year are based on base year financial and stastical reports submitted by hospitals to the Office of Mental Health. The base year is the fiscal year two years prior to the rate year. The financial and statistical reports are subject to audit by the Office of Mental Health.

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Allowable base year operating costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. To be allowable, costs must be reasonable and must relate to patient care. Allowable costs may not include costs for services which have not been approved by the Commissioner.

Hospitals that were issued an operating certificate subsequent to July 1, 1986, which have no previous costs or operating experience will submit a budget report as the basis for calculating a prospective Medicaid rate. The budget report will contain all proposed revenues and expenses for the period under consideration. The operating cost component of the rate will be the lower of the calculated per diem, utilizing the approved budgeted operating costs and the approved budgeted patient days, or 110% of the statewide weighted average of the operating cost component of all private psychiatric hospitals. The hospital is required to submit a cost report after it has operated for six months at a minimum occupancy level of at least 75%. This cost report will be used to set a cost-based rate for the hospital effective the first day of the cost report period.

In determining allowable operating costs for any base year beginning January 1, 1985 there is applied a growth factor limitation, which is derived from the trend factors calculated by the Office of Health Systems Management of the New York State Department of Health plus 2%. In determining allowable costs for any rate year, there is applied to allowable base year costs the trend factor determined by the Office of Health Systems Management of the New York State Department of Health for Medicaid rates of payments to hospitals. The trend factor is determined in accordance with New York Codes, Rules and Regulations, Title 10, Section 86-1.15.

Appendix F

Appeals from rate determinations are heard by the Commissioner. The Commissioner may hear requests for rate revisions which are based on errors in the calculation of the rate or in the data submitted by the facility or based on significant changes in operating costs resulting from changes in services, programs or capital projects approved by the Commissioner in connection with OMH's certificate of need procedures. Revised rates must be certified by the Commissioner and approved by the Director of the Budget.

2. CAPITAL COSTS

To allowable operating costs are added allowable capital costs. Allowable capital costs are determined by the application of the principles developed for determining reasonable cost payments under the Medicare program. Allowable capital costs include an allowance for depreciation and interest. A return on equity, as determined in the Provider Reimbursement Manual, HIM-15, Chapter 12, is allowed for proprietary hospitals. To be allowable, capital expenditures subject to the Office of Mental Health's certificate of need procedures must be reviewed and approved by the Office of Mental Health.

The allowed capital cost component of the budget based rate will be based upon approved annual budgeted costs and approved budgeted patient days retroactively adjusted to actual certified costs divided by the higher of the actual patient days or the approved budgeted patient days.

Transfer of Ownership

In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital which has undergone a change of ownership, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisistion cost of such asset to the owner of record as of July 18, 1984 (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or in the acquisition cost of such asset to the new owner.

3. METHODOLOGY TO TAKE INTO ACCOUNT THE SITUATION OF HOSPITALS WHICH SERVE A DISPROPORTIONATE NUMBER OF LOW INCOME PATIENTS WITH SPECIAL NEEDS.

Effective July 1, 1988, the rates will be adjusted in accordance with Section 1902 (a)(13)(A) of the Social Security Act and Section 4112 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) to account for Private Psychiatric Hospitals which serve a disproportionate number of low income patients. A Private Psychiatric Hospital qualifies for an adjustment if its low income inpatient utilization rate exceeds 25 percent. Low income utilization rate is defined as the sum (expressed as a percentage) of the fraction calculated as follows:

- Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments for the latest available cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

- The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMO's, Medicare or Blue Cross.

For qualifying Private Psychiatric Hospitals, the rate adjustment will be calculated in accordance with the rules established under Section 1886 (d)(5)(F)(iv) of the Social Security Act for the Medicare Program.

4. REDUCED PAYMENT FOR INAPPROPRIATE LEVEL OF CARE

— If it is determined by a utilization review committee that a Medicaid recipient no longer requires inpatient psychiatric hospital services but must remain in the hospital because a medically necessary long term care bed is not available in the community ("alternate care determination"), and it is determined by the Commissioner that there is a significant excess of operational beds at the hospital or in private psychiatric hospitals located in the OMH region in which the hospital is located, the hospital will be reimbursed at a rate equal to the average Medicaid skilled nursing facility or intermediate care facility rate within the State, as appropriate, at the time such services were furnished. For purposes of this paragraph, a significant excess of operational beds exists if the occupancy rate for the hospital for the most recently beds exists if the occupancy rate for the hospital for the most recently reported twelve month period is less than 80%, of the hospitals bed capacity, as stated on the operating certificate issued by the Office of Mental Health. A significant excess of operational beds exists in the OMH region if the overall occupancy rate for private psychiatric hospitals in the region is less than 80%. Alternate care days are counted as occupied beds. Effective October 1, 1984, occupancy rates will be determined without including alternate care days.

Alternate care determinations must be reported to the Office of Mental Health ("OMH") on such forms and in such manner as shall be prescribed by OMH. OMH will notify providers of procedures for collecting and reporting data.

Appendix F

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

TRANSMITTAL NUMBER
87-30

STATE
New York

PROGRAM IDENTIFICATION
XIX

PROPOSED EFFECTIVE DATE
July 1, 1988

TYPE OF PLAN MATERIAL
☒ AMENDMENT

FEDERAL REGULATION CITATION
42 CFR Part 447.250-271

NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Part III
Pages 1, 2, 3

Appendix F

NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT
Attachment 4.19-A, Part III
Pages 1, 2, 3

SUBJECT OF AMENDMENT
Methods and Standards for Establishing Payment Rates-Private Psychiatric Hospitals

GOVERNOR'S REVIEW
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

SIGNATURE OF STATE AGENCY OFFICIAL
Cesar A. Perales

TYPED NAME:
Cesar A. Perales

TITLE:
Commissioner

DATE:
June 30, 1988

RETURN TO:
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

* * *

Appendix F

STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

MARIO M. CUOMO
GOVERNOR

June 29, 1988

Dear Commissioner Perales:

My staff has reviewed and approved the Department's amendments (Submittals 88-29, 88-30 and 88-31) to the State Plan under Title XIX of the Social Security Act (Medical Assistance).

You may submit this letter to the U.S. Department of Health and Human Services as evidence of my review.

Sincerely

s/ illegible

Honorable Cesar A. Perales
Commissioner
Department of Social Services
40 North Pearl Street
Albany, New York 12243

Appendix F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to DMD-R:1

Region II
Federal Building
26 Federal Plaza
New York NY 10278

Cesar A. Perales, Commissioner
New York State Department of
Social Services
Ten Eyck Office Bldg.
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Perales:

This is to inform you that we have approved your request concerning disproportionate payment adjustments made by New York State in accordance with the special rule described in section 1923(e) of the Social Security Act.

The State has adequately addressed our concerns regarding the applicability of the special rule in correspondence dated December 19, 1989 and further information submitted thereafter.

Since this special rule should be applied on a statewide basis including psychiatric and specialty hospitals, you may wish to withdraw previously submitted Plan amendments which are currently pending (NY 88-30, NY 88-31).

We appreciate the cooperation of your staff in working to resolve the issues which arose during our review. Please contact Debra K. Mayo of my staff at (212)-264-2783 if there are any questions on this matter.

Sincerely,

s/ Arthur J. O'Leary
Associate Regional Administrator
Division of Medicaid

cc: Jo-Ann Costantino
Linda Odeen
Raymond Sweeney
John Shepardson
Thomas Maul

APPENDIX G — RELEVANT STATUTES

42 U.S.C. § 1396

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must —

* * *

(13) provide —

(A) for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this subchapter) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

* * *

§ 1396r-4. Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

(a) Implementation of requirement

(1) A State plan under this subchapter shall not be considered to meet the requirement of section 1396a(a)(13)(A) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that —

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) of this section which meets the requirement of subsection (d) of this section), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) of this section.

(2)(A) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, the State plan amendment described in paragraph (1), consistent with subsection (c) of this section, effective for inpatient hospital services provided on or after July 1, 1989.

(B) In order to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1990, the State must submit to the Secretary by not later than April 1, 1990, the State plan amendment described in paragraph (1), consistent with subsection (c) of this section, effective for inpatient hospital services provided on or after July 1, 1990.

(C) If a State plan under this subchapter provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1396a(a)(13)(A) of this title as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.

(3) The Secretary shall, not later than 90 days after the date a State submits an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement.

(4) The requirement of this subsection may not be waived under section 1396n(b)(4) of this title.

(b) Hospitals deemed disproportionate share

(1) For purposes of subsection (a)(1) of this section, a hospital which meets the requirement of subsection (d) of this section is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under a State plan approved under this subchapter in a period, and the denominator of which is the total number of the hospital's inpatient days in that period. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under this subchapter and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage) —

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under this subchapter).

(c) Payment adjustment

In order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either —

(1) be in an amount equal to at least the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1395ww(a)(4) of this title), and (B) the hospital's disproportionate share adjustment percentage (established under section 1395ww(d)(5)(F)(iv) of this title);

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and

(without regard to whether the hospital is described in subparagraph (A) or (B) of subsection (b)(1) of this section) for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2) of this section) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State or the hospital's low-income utilization rate (as defined in subsection (b)(3) of this section); or

(3) provide for a minimum specified additional payment amount (or increased percentage payment) that varies according to type of hospital under a methodology that —

(A) applies equally to all hospitals of each type; and

(B) results in an adjustment for each type of hospital that is reasonably related to the costs, volume, or proportion of services provided to patients eligible for medical assistance under a State plan approved under this subchapter or to low-income patients.

except that, for purposes of paragraphs (1)(B) and (2)(A) of subsection (a) of this section, the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to at least one-third of the increase otherwise applicable under this subsection (in the case of such paragraph (1)(B)) and at least two-thirds of such increase (in the case of such paragraph (2)(A)). In the case of a hospital described in subsection (d)(2)(A)(i) of this section (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1395ww(d)(5)(F)(vi) of this title) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) of this section to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.

(d) Requirement to quality as disproportionate share hospital

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under this subchapter or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital —

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of December 22, 1987.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1395ww of this title), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(e) Special rule

(1) A State plan shall be considered to meet the requirement of section 1396a(a)(13)(A) of this title (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) of this section if (A)(i) the plan provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984, or (ii) the plan as of January 1, 1987, provided for payment adjustments based on a statewide pooling arrangement involving all acute care hospitals and the arrangement provides for reimbursement of the total amount of uncompensated care provided by each participating hospital, and (B) the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection.

(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a statewide basis, beginning on July 1, 1988 —

(A) the requirements of subsections (b) and (c) of this section shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied, and

(B) subsection (d)(2)(B) of this section shall apply to hospitals located in urban areas, as well as in rural areas.

(2)

No. 95-1427

Supreme Court, U.S.
FILED
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CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

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RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

Petitioner,

—against—

RICHARD C. SURLES, Ph.D., Commissioner of the Office of Mental Health of the State of New York, and GREGORY KALADJIAN, Acting Commissioner of the State of New York, Department of Social Services,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE NEW YORK SUPREME COURT, APPELLATE DIVISION, THIRD DEPARTMENT

BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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IN THE

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OCTOBER TERM, 1995

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RYE PSYCHIATRIC HOSPITAL CENTER, INC.,

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BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

INTRODUCTION

Petitioner, Rye Psychiatric Hospital Center, Inc. ("petitioner"), is a private, for-profit psychiatric hospital with approximately 35 beds. Petitioner commenced the underlying proceeding in State Supreme Court, seeking, *inter alia*, a retroactive 5% upward "disproportionate share adjustment" of its Medicaid reimbursement rates for the 1986 through 1991 rate years, even though it already received 100% Medicaid reimbursement for its Medicaid patients and operated at a profit. State Supreme Court, Albany County, denied this relief, and the State Appellate Division, Third Department, affirmed. Both courts held that petitioner was not entitled to the disproportionate share adjustment because New York, through its bad debt and charity pools for general hospitals, had received a "special rule exemption" from the disproportionate share adjustment requirement. The State Court of Appeals denied petitioner's motion for leave to appeal. The petition for a writ of certiorari should be denied because the State courts did not decide a federal issue when they denied petitioner's request for a disproportionate share adjustment. Moreover, the equal protection claim alleged here was not alleged in the State court petition or amended petition and the State courts did not, therefore, address it. In any event, since private psychiatric hospitals such as petitioner can turn away patients based on ability to pay and thereby operate at a profit, whereas the deficit-ridden hospitals of the State Office of Mental Health ("State OMH") must accept all comers, it was rational for the State not to have pursued disproportionate share adjustment plan amendments for the private psychiatric hospitals. Finally, petitioner's claims pursuant to 42 U.S.C § 1983 for retroactive monetary relief against the State are barred by sovereign immunity.

STATEMENT OF THE CASE

A. The Special Rule Exemption To The Disproportionate Share Requirement

Medicaid is a joint federal and state program which provides medical care to those who otherwise would be unable to afford it. 42 U.S.C. §§ 1396, *et seq*. The program is administered by the states in accordance with a plan that must be approved by the United States Department of Health and Human Services ("HHS"), Health Care Financing Administration ("HCFA"). 42 U.S.C. § 1396a(b); *see generally* 42

CFR Part 447. In accordance with 42 U.S.C. § 1396a(a)(5), the State Department of Social Services ("State DSS") is the single state agency designated to administer the Medicaid program for the State of New York. N.Y. Social Services Law § 363-b (McKinney 1992). Other New York State agencies have regulatory responsibility over institutional Medicaid providers: the Department of Health ("State DOH") establishes the Medicaid reimbursement rates for general hospitals; State OMH sets the rates for freestanding psychiatric hospitals.

A state Medicaid plan must set forth the method for reimbursing health care providers. Under the Boren Amendment to the Medicaid Act, the state must make assurances satisfactory to the Secretary of HHS that reimbursement rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. 42 U.S.C. § 1396a(a)(13)(A). One of the requirements for a state Medicaid plan or plan amendment is that it provide for "methods and standards used to determine payment rates [which] take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs." 42 CFR 447.253(b)(ii)(A). *See also* 42 U.S.C. § 1396a(a)(13)(A) ("disproportionate share provision") and § 1396r-4(a),(e) ("special rule exemption"). In 1987, Congress enacted the Omnibus Budget Reconciliation Act, P.L. 100-203 ("OBRA"), which contained amendments that sought to effectuate the states' compliance with the disproportionate share provision. *See* H.R. Rep. No. 101-247, 101st Cong., 1st Sess., p. 481.

Pursuant to section 4112 of OBRA, states were required to submit plan amendments, effective July 1, 1988, to implement the disproportionate share requirement, except that states which satisfied OBRA's "special rule" exemption to the disproportionate share provision did not have to submit such plan amendments. A state satisfied the special rule exemption and was deemed to be in compliance with the disproportionate share provision of 42 U.S.C. § 1396a(a)(13)(A) if (1) the state's plan "provided for payment adjustments based on a pooling arrangement involving a majority of the hospitals participating under the plan for disproportionate share hospitals as of January 1, 1984 . . .", and (2) "the aggregate amount of the payment adjustments under the plan for such hospitals is no less than the aggregate amount of such adjustments" in the absence of an exemption. 42 U.S.C. § 1396r-4(e).

Only states which did not qualify for the special rule exemption were required to submit plan amendments which provided for minimum "payment adjustments" to disproportionate share hospitals. Under the plan amendments, a "disproportionate share hospital" was defined as one whose aggregate patient revenues from Medicaid and state and local cash subsidies exceed 25% of its total patient revenues. 42 U.S.C. § 1396r-4(b).

In early 1988, HCFA advised State DSS of OBRA's provisions regarding the disproportionate share requirement and sought to ascertain how the State of New York proposed to comply. By letter dated May 17, 1988, State DSS replied by requesting HCFA to grant New York the special rule exemption under OBRA for general hospitals regulated by State DOH. State DSS represented that New York had been complying with the disproportionate share provision of § 1396a(a)(13)(A) for such general hospitals since 1983, by way of a bad debt and charity pool to aid general hospitals serving those unable or unwilling to pay for inpatient services. In a letter dated August 22, 1989 which State DSS forwarded to HCFA, State DOH estimated that New York's payments from its bad debt and charity care pools totaled $91 million, whereas the State's disproportionate share payments would be approximately $39 million if it were not exempt by special rule from OBRA's disproportionate share requirement.

In addition, by letter dated June 30, 1988, State DSS submitted plan amendments for revisions to the reimbursement methodology utilized by State OMH for the facilities which it regulated. The amendments provided for disproportionate share adjustments to be paid to OMH-operated public psychiatric hospitals (NY 88-29), private psychiatric hospitals (NY 88-30), and residential treatment facilities (NY 88-31).

By letter dated February 27, 1990, HCFA informed State DSS that it had approved New York's request for the special rule exemption. (Appendix F to the Petition at 39a-40a.) HCFA added that "[s]ince this special rule should be applied on a statewide basis including psychiatric and specialty hospitals, you may wish to withdraw previously submitted Plan amendments which are currently pending (NY 88-30, NY 88-31)." *Id.* In accordance with HCFA's suggestion, State DSS did withdraw these plan amendments covering private psychiatric hospitals and residential treatment facilities. HCFA subsequently approved the plan amendments for OMH-operated facilities.

HCFA concluded that New York was applying the special rule exemption from the disproportionate share adjustment requirement on a statewide basis. HCFA stated that the statewide requirement was met if a "majority of hospitals as of January 1, 1984" participated in a pooling arrangement that otherwise satisfied the requirements for a special rule (R. 163).[1] HCFA then added that New York's general hospitals covered by the State's bad debt and charity care pool represented a "majority of hospitals" in New York as of that date, even though private psychiatric hospitals and residential treatment facilities did not participate in any pooling arrangement (R. 162-63).

B. The State Court Decisions

Petitioner commenced this proceeding in Supreme Court, Albany County, pursuant to article 78 of the New York Civil Practice Law and Rules ("CPLR"), challenging State OMH's adoption of a "minimum utilization factor" to compute petitioner's Medicaid reimbursement rates.[2] As originally drafted, the petition did not raise a claim that petitioner was entitled to a disproportionate share adjustment to its Medicaid reimbursement rates. Rather, petitioner brought the proceeding to implement retroactively the decision of the federal district court in *Rye Psychiatric Hospital Center, Inc. v. Surles*, 768 F. Supp. 82 (S.D.N.Y. 1991), which nullified the regulation establishing the minimum utilization factor.[3]

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[1] "R__" refers to the Record on Appeal in the State courts.

In its amended pleading, petitioner alleged that without the minimum utilization factor, it was entitled to a 5% disproportionate share adjustment pursuant to 42 U.S.C. §§ 1396r-4(c) and 1395ww(d)(5)(F)(iv)(II) for rate years 1986 through 1991. Petitioner brought its claims for retroactive disproportionate share adjustments to its 1986 through 1991 Medicaid reimbursement rates pursuant to 42 U.S.C. § 1983, and petitioner sought attorney's fees under 42 U.S.C. § 1988. Petitioner also asserted that "[r]espondents' refusal . . . to determine Rye's status as a disproportionate share hospital for the period January 1, 1986 to the present *without use of the minimum utilization adjustment*" denied it equal protection and due process. The amended petition did not assert the equal protection violation alleged in the petition for certiorari based on the receipt by OMH hospitals of disproportionate share adjustments. (*See* Respondents' Appendix.)

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[2] The minimum utilization factor was designed to discourage hospitals from underutilizing certified bed space and to encourage more efficient and economical operation. In calculating a psychiatric hospital's Medicaid reimbursement rate using the minimum utilization factor, OMH would "impute" enough patient days of care to an underutilized hospital to meet the minimum utilization requirement of seventy-five percent of a hospital's certified beds. In each of the rate years at issue, petitioner failed to fill enough of its certified beds to meet the minimum utilization requirement and its rates were, accordingly, calculated in part on the basis of imputed days.

[3] The district court held that the State had not made formal findings, as required by the Boren Amendment, that the regulation yielded rates which "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. 42 U.S.C. § 1396a(a)(13)(A)." 768 F. Supp. at 86-89.

In July 1992, Supreme Court, Albany County, granted the article 78 petition to the extent of directing respondents to recompute petitioner's Medicaid reimbursement rates for the years 1986 through 1991 without the reduction imposed by the minimum utilization factor. With regard to petitioner's request for an additional 5% payment on the ground it qualifies as a disproportionate share hospital, the court concluded that a hearing was needed to determine whether the State had an exemption from the disproportionate share requirement. (Appendix E to the Petition, at 19a-22a.)

The hearing was held in February 1993. Respondents introduced an affidavit and supporting documentation from the Regional Director of HCFA's Division of Medicaid, stating that on February 27, 1990, New York had been approved for a special rule exemption from the disproportionate share requirement because it had a pooling arrangement involving public, voluntary and proprietary general hospitals, providing financial aid to those hospitals which serve patients unable or unwilling to pay for inpatient services (R. 158-64). HCFA found that the general hospitals in the bad debt and charity pool represented a majority of the disproportionate share hospitals in New York as of January 1, 1984 (R. 162-63).

The HCFA documentation introduced at the hearing also stated that HCFA was aware that private psychiatric hospitals were not included in the bad debt and charity pool or any other pooling arrangement, but that the State's existing pooling arrangement alone satisfied the requirements for the statewide exemption from the disproportionate share payment adjustment, since it involved a majority of the State's hospitals.[4] HCFA stated further that it intended the exemption to apply statewide and to cover psychiatric hospitals not included in any pooling arrangement.

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[4] Private psychiatric hospitals comprise approximately 5% of all hospitals in New York State and their total bed capacity represents an even smaller percentage of total hospital beds statewide.

In June 1993, State Supreme Court found from the evidence at the hearing that HCFA had granted New York a special rule exemption from the disproportionate share requirement based on the State's representation that it had a bad debt and charity pooling arrangement involving general hospitals as of January 1, 1984. (Appendix D to the Petition at 14a.) The court also concluded that petitioner's equal protection claim must be dismissed because there was a rational basis for the State to exclude private psychiatric hospitals such as petitioner from the pooling arrangement, which is intended to reduce the deficits experienced by public hospitals as providers of last resort. The court stated that private psychiatric hospitals, by contrast, receive 100% Medicaid reimbursement and operate at a profit because they can turn away patients based on inability to pay. *Id.* at 14a-15a. State Supreme Court's decision did not address whether respondents violated petitioner's equal protection rights by obtaining disproportionate share adjustments for State OMH hospitals but not for private psychiatric hospitals, since the issue was not raised in the petition or amended petition.

In an order entered on August 3, 1995, the Appellate Division, Third Department, held that the State did not have to include a disproportionate share adjustment in the rate paid to disproportionate share hospitals because "Supreme Court's finding that the State has an exemption under the 'special rule' from the Boren Amendment's disproportionate share adjustment requirement is correct." (Appendix B to the Petition at 4a-5a.) The Third Department rejected petitioner's contention that the State was required to prove that it was entitled to the exemption, noting that federal law (42 U.S.C. § 1396r-4(e)) does not require states to make findings in support of its request for an exemption under the special rule, and the special rule does not implicate the Boren Amendment's requirement for findings since such request does not involve a change in payment method or standards (citing 42 CFR 447.253(b)). *Id.* at 5a. The court concluded that "petitioner had the burden of proof on the issue of compliance with the Medicaid laws (*see*, *Multicare Medical Ctr. v. Washington*, 768 F. Supp. 1349, 1389)." *Id.* at 4a-5a.

The Third Department then rejected petitioner's equal protection claim that its exclusion from the bad debt and charity pools that are available to the State's major public hospitals and voluntary and private proprietary hospitals violated equal protection. The court concluded that "there is a rational basis for excluding private psychiatric hospitals from receiving allowances from the subject pools" (*id.* at 6a) because the purpose of the bad debt and charity pools established by the State's Public Health Law is to cushion the losses sustained by general hospitals from bad debts and the costs of charity care, "the record evidence shows that private psychiatric hospitals have a relatively low percentage of uncompensated care patients and are profitable enterprises," and petitioner offered no proof on this issue.

Petitioner then moved for permission in the State Court of Appeals to appeal the Third Department's order. The Court of Appeals denied the motion by order entered December 7, 1995. (Appendix A to the Petition, at 1a.)

REASONS FOR DENYING THE WRIT

A. Petitioner's Challenge To The State Courts' Findings That The State Has A Special Rule Exemption From The Disproportionate Share Adjustment Requirement Does Not Raise A Federal Issue For This Court's Review

State Supreme Court, following an evidentiary hearing, found that the State was granted a special rule exemption from the disproportionate share adjustment requirement in the 1987 OBRA. The State, through its special rule exemption, has thus satisfied OBRA and is not required to provide disproportionate share adjustments to private psychiatric hospitals such as petitioner, even though they do not participate in the bad debt and charity pools. Since the State is exempt by special rule, petitioner is not entitled to any disproportionate share adjustments under 42 U.S.C. § 1396r-4, even if it were to otherwise demonstrate its eligibility.[5]

Petitioner now asserts that the State courts erred in concluding that the State was entitled to the special rule exemption. (Petition at 16-20.) The Court should not grant the writ of certiorari to review the question of whether the exemption was properly granted to the State, since this was not the issue before the State courts. Nor did petitioner seek relief from HCFA, the federal agency that granted the exemption. Indeed, the State courts would not have had jurisdiction to invalidate HCFA's determination granting the exemption to the State based on the State's bad debt and charity pools in effect on January 1, 1984.

Accordingly, the only questions which can be raised in this petition are whether the evidence at the hearing established the existence of the State's special rule exemption based on its pooling arrangements, and whether petitioner met its burden of proof in the context of the State court article 78 proceeding. Since neither question raises a federal issue and both were correctly decided, the writ should be denied.

B. Petitioner's Equal Protection Challenge Does Not Merit This Court's Review

Petitioner's equal protection argument as now framed to this Court was not properly raised in the State court proceedings. The amended petition alleged only that respondents violated its equal protection rights by failing to take into account the elimination of the minimum utlization factor in determining whether petitioner was a disproportionate share hospital. In the Appellate Division, petitioner alleged that it was denied equal protection by its exclusion from the bad debt and charity pools, and because it is unable to obtain a disproportionate share adjustment whereas State OMH hospitals receive such adjustments. Petitioner now bases its equal protection claim only on its alleged disparate treatment compared to State OMH hospitals. Although petitioner raised this argument in the Appellate Division and in its motion for leave to appeal to the State Court of Appeals, it was not preserved because it was not raised in the petition or amended petition. Accordingly, the State courts did not address it. Since petitioner did not follow state procedures for the preservation of claims with regard to the equal protection issue presented in its petition for certiorari, it is not preserved for this Court's review.

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[5] Petitioner erroneously claims that it qualifies as a disproportionate share hospital because it has a 25% low-income utilization rate. In the State courts, respondents disputed petitioner's claim and the courts never expressly found that petitioner qualified as a disproportionate share hospital.

In any event, the State's decision, at HCFA's suggestion, to withdraw the plan amendments to provide disproportionate share adjustments for private psychiatric hospitals did not violate equal protection. A State's classification in the area of economics will survive an equal protection challenge so long as the classification has a rational relation to a legitimate State objective. *See Hodel v. Indiana*, 452 U.S. 314, 331-32 (1981); *Western and Southern Life Insurance Co. v. State Board of Equalization of Califiornia*, 451 U.S. 648, 656-57 (1981). Here, the State, with HCFA's approval, implemented plan amendments to provide disproportionate share adjustments to State OMH hospitals because these hospitals are providers of last resort and incur huge deficits. The State, also with HCFA's approval, chose not to pursue plan amendments for the private, for-profit psychiatric hospitals such as petitioner because they can turn away patients who are unable to pay and are thus able to operate at a profit.

As providers of last resort, public hospitals are required to admit and treat patients regardless of ability to pay (R. 125-30). Accordingly, they provide a large volume of uncompensated care and operate at huge deficits aggregating about a half billion dollars per year, which are reduced only in part by the disproportionate share adjustments (R. 125-30). By contrast, private psychiatric hospitals generally operate at a profit (R. 125-30). Petitioner's bad debt in 1990, for example, was only 1.5% of its total hospital charges (R. 61, 129). Furthermore, the Medicaid rates set for private psychiatric hospitals cover the full cost of their Medicaid patients (R. 144.)

Petitioner thus received its full Medicaid reimbursement rate for treating its Medicaid patients. State OMH hospitals, by contrast, do not receive any reimbursement or payment for the majority of their patients. Although over 90% of the patients at OMH hospitals are Medicaid "eligible," 60-70% of those patients do not receive Medicaid because of Medicaid's exclusion for patients between the ages of 22 to 64 years old in institutions for mental diseases. (R. 130, 144). Accordingly, disproportionate share adjustment payments to private psychiatric hospitals would unduly enrich them.[6] As the Appellate Division noted, petitioner offered no proof to the contrary. Since private psychiatric hospitals such as petitioner can select patients based on ability to pay and thereby generate a profit, whereas OMH hospitals cannot, it was rational for the State not to have pursued disproportionate share adjustment plan amendments for the private psychiatric hospitals.[7]

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[6] Petitioner erroneously suggests that disproportionate share adjustments go to Medicaid patients (Petition at 21); such payments go to hospitals, not patients.

[7] Beginning in 1992, the federal government placed a cap on disproportionate share adjustment payments for each state. Accordingly, requiring the State to make disproportionate share adjustment payments to profitable private psychiatric hospitals would reduce the amount of disproportionate share funds available to deficit-ridden State OMH hospitals.

Therefore, petitioner's equal protection claim, even if it were preserved, does not merit this Court's review.

C. Petitioner's Claim For Retroactive Monetary Relief Is Barred By Sovereign Immunity

In the amended petition, petitioner alleged that respondents' failure to provide it with disproportionate share adjustments to its prior Medicaid reimbursement rates violated its rights under 42 U.S.C. § 1983. Petitioner sought retroactive monetary damages and also attorney's fees under 42 U.S.C. § 1988. However, 42 U.S.C. § 1983 does not authorize claims against states or suits against state officials acting in their official capacities for money damages and other retroactive relief. *Will v. Michigan*, 491 U.S. 58, 71 (1989). Here, respondents were sued in their official capacities for retroactive adjustments to petitioner's 1986-1991 Medicaid rates. Such relief is against the State, payable out of the State treasury and, accordingly, not cognizable under § 1983.[8]

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[8] Even assuming that there was merit to petitioner's claims and that retroactive monetary relief was not jurisdictionally barred, petitioner still would not be entitled to its claimed 5% disproportionate share adjustment until the following occurred. First, the State would need a disproportionate share plan amendment approved by HCFA for private psychiatric hospitals. Second, petitioner would have to show that it is a disproportionate share hospital, since it erroneously included as Medicaid revenue Medicare payments to its patients who are "qualified medicare beneficiaries." The payments for such QMBs are Medicare, not Medicaid, payments. *See New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992), *cert. den.*, ___ U.S. ___, 113 S. Ct. 461 (1992). Without inclusion of these Medicare revenues, petitioner would not qualify as a disproportionate share hospital, except for rate year 1991. Third, even if petitioner qualified as a disproportionate share hospital, the Medicaid Act provides the states with three options for making disproportionate share adjustment payments in the absence of a "special rule" exemption and does not automatically require the 5% upward adjustment which petitioner claims. 42 U.S.C. § 1396r-4(c).

CONCLUSION

The petition for a writ of certiorari should be denied. New York State is not in violation of the Boren Amendment to the Medicaid Act because the State has a special rule exemption from the disproportionate share adjustment requirement. Petitioner's claim that the exemption was improperly granted by HCFA was not, and could not have been, decided by the state courts, and does not therefore raise a federal issue. Petitioner's equal protection claim is not preserved for review by this Court because it was not properly raised in the state courts. In any event, it was rational for the State, with HCFA's approval, not to have pursued disproportionate share adjustment plan amendments for the private psychiatric hospitals since they can turn away patients based on ability to pay and operate at a profit, whereas the deficit-ridden State OMH hospitals must accept all comers. Finally, petitioner could not, in any event, obtain retroactive monetary damages in the State courts pursuant to 42 U.S.C. § 1983.

Dated: New York, New York
April 29, 1996

Respectfully submitted,

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APPENDIX—AMENDED VERIFIED PETITION
(exhibits omitted)

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF ALBANY

Index No. 5174/90

APPLICATION OF RYE PSYCHIATRIC
HOSPITAL CENTER, INC.,

Petitioner,

For a Judgment Pursuant to ARTICLE 78 of the CPLR,

—against—

RICHARD C. SURLES, Ph.D., Commissioner of the Office of Mental Health of The State of New York, and GREGORY KALADJIAN, Acting Commissioner of The State of New York, Department of Social Services,

Respondents.

AMENDED VERIFIED PETITION

Petitioner Rye Psychiatric Hospital Center, Inc. ("Rye") alleges:

1. Rye is a corporation duly organized and existing under the laws of the State of New York with its principal place of business located at 754 Boston Post Road, Rye, New York.

2. Rye owns and operates an investor-owned private free standing psychiatric hospital located at 754 Boston Post Road, Rye, New York.

3. At all material times Rye's patients have included individuals whose medical treatment is the financial responsibility of the State of New York under the Medicaid program. (Such individuals are hereinafter referred to as "Medicaid patients").

4. Under the provisions of Social Services Law § 367 and other applicable law, Rye's costs of care of Medicaid patients are a charge against, and a contractual responsibility of, the state.

5. The Medicaid program is jointly funded by the federal government and the State of New York.

6. Respondent Richard C. Surles, PhD., is the Commissioner of the New York State Office of Mental Health ("OMH") and is empowered, pursuant to § 31.04 of the Mental Hygiene Law, to promulgate regulations affecting psychiatric hospitals in New York. He is also responsible for the preparation of a state plan for medical assistance to recipients under Title XIX of the Social Security Act (42 U.S.C. § 1369a, *et seq.*), which governs the Medicaid program. In addition, Commissioner Surles is responsible for determining the rate at which Rye will be paid by the State of New York for its costs of care of Medicaid patients. All of the actions attributed to OMH herein are the responsibility of Commissioner Surles.

7. Respondent Gregory Kaladjian is the Acting Commissioner of the Department of Social Services of the State of New York ("DSS") (successor to Cesar A. Perales who was the Commissioner at the times relevant hereto), which is the designated single state agency for medical assistance, and is responsible, among other things, for making the assurances and findings required under 42 CFR § 447.253 *et seq.*, to the U.S. Department of Health and Human Services ("HHS") with respect to a state plan establishing rates of payment to psychiatric hospitals in New York State for their costs of care of Medicaid patients.

8. Under 42 U.S.C. § 1396a(a)(13)(A), a state plan under the Medicaid program must provide for payment to health care providers such as Rye "through the use of rates . . . which the state [through Commissioner Kaladjian] finds, and makes assurances satisfactory to the Secretary [of HHS], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to in-patient hospital services of adequate quality . . . ." In addition, the state's rates must "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . ." (the "Boren Amendment") The foregoing requirements are also embodied in 42 CFR § 447.253.

9. On April 30, 1990, Rye received an undated letter from OMH that enclosed a copy of "the Final Medicaid in-patient rate computation schedule for [Rye] for the rate year beginning January 1, 1986 through December 31, 1986." (A copy of that letter and the enclosed rate computation schedule are annexed hereto as Exhibit A). The 1986 Final Medicaid Reimbursement Rate established in that letter was $226.55 per patient per day.

10. The regulation incorporating the "minimum utilization factor" was promulgated by Commissioner Surles (or his predecessor), and Commissioner Perales purported to find it to be in compliance with applicable federal law and regulations, and made assurances but no findings to that effect to HHS. That rate was established unlawfully by OMH through the introduction of a "minimum utilization factor" into its Medicaid rate computation methodology. (*See* 14 NYCRR § 577.7(g)). On July 2, 1991, United States District Judge Gerard L. Goettel found the regulation to be null and void as

violating the Boren Amendment to the Social Security Act 42 U.S.C. § 1396a(a)(13)(A). 768 F Supp. 82 (S.D.N.Y. 1991). Respondents took no appeal from the judgment entered on this opinion and are bound thereby.

11. The "minimum utilization factor" had been applicable only to private psychiatric hospitals and not to any other type of hospital, including general hospitals with psychiatric divisions.

12. Essentially, the "minimum utilization factor" provided that if a private psychiatric hospital did not achieve an overall occupancy rate equal to 75% of its certified bed capacity in the "base" year (two years before the rate year) which OMH used as a starting point for determining the hospital's allowable costs, a fictitious number of "patient days" would be imputed to the hospital in the base year to artificially achieve a 75% occupancy rate. Thus, when the total Medicaid allowable costs of such a private psychiatric hospital was computed by dividing its allowable costs by the fictitious number of "patient days", a rate would be established for its Medicaid reimbursement.

13. In Rye's case, its actual occupancy rate was below 75% in both the base year (1984) and the rate year (1986) due directly to its ability to efficiently treat and release patients earlier than comparable hospitals. However, as a result of OMH's imputation of a number of fictitious patient days to Rye, OMH unlawfully reduced Rye's Medicaid payment rate for 1986 and subsequent years.

14. Rye's actual number of patient days in 1986 was 8,449; the number fictitiously imputed by OMH is 11,255. By thus artificially increasing the number of patient days by which Rye's allowable costs would be divided in arriving at Rye's 1986 Medicaid rate, OMH unlawfully reduced the amount otherwise payable to Rye per Medicaid patient per day from $282.46 to $226.55.

15. As a result of OMH's unlawful reduction of Rye's 1986 Medicaid rate through the use of the "minimum utilization factor", Rye has been underpaid $110,925.44 for its costs of care of Medicaid patients for the year 1986.

16. In addition, in 1986, and in each year since then to the present, Rye has treated a disproportionate share of low income patients with special needs as that term is used in 42 U.S.C. §§ 1396r-4(c) and 1395ww(d)(5)(F)(iv)(II), Rye is entitled to an additional five percent (5%) of its 1986 proper Medicaid reimbursement of $564,825 or $28,241. Since in 1986 Rye received $449,475, a total of $143,591 has been underpaid for that year.

17. Pursuant to 14 N.Y.C.R.R. § 577.7(d) each year, OMH established "provisional" rates (based upon two-year-old cost reports submitted by Rye) which it paid Rye's private hospital Medicaid reimbursement subject to an audit, after which the rates become final. The last year for which Rye has received such a "final" rate is 1986 (See Exhibit A). OMH had not informed Rye of a new "provisional" rate for (1991) until January 23, 1992.

18. In calculating "provisional" rates for 1987 through July 2, 1991, OMH applied the minimum utilization factor, in each year substantially reducing the amount of Rye's Medicaid reimbursement. Following, are the amounts of Medicaid reimbursements payable to Rye from 1987 to the present without the minimum utilization factor, the amounts actually paid, and the difference to which Rye is entitled, including disproportionate share adjustment ("DPS"):

	Correct Amount Before DPS	DPS Adjustment	Amount Paid	Amount Underpaid and Due To Rye
1987	$564,814	$28,241	$423,760	$169,295
1988	655,105	32,755	468,860	219,000
1989	559,710	27,986	399,624	188,072
1990	926,764	46,338	625,289	347,813

	Correct Amount Before DPS	DPS Adjustment	Amount Paid	Amount Underpaid and Due To Rye
1991 (to 7/2)	1,106,616	55,331	746,635	415,312
1991 (7/2-12/31)	1,196,728	59,836	1,196,728	59,836
1992 (to 1/23)	117,644	5,882	117,644	5,882
			Total	$1,405,210

19. Rye requested that Judge Goettel order respondents to complete audits that would make the rates for prior years final (14 N.Y.C.R.R. § 577.7(d)) and do so without application of the minimum utilization factor. Rye further requested that upon completion of such audits respondents be ordered to pay Rye the amount unlawfully withheld for the years 1986 to the present including the disproportionate share adjustment.

20. In an Opinion and Order dated November 7, 1991 Judge Goettel found that the Eleventh Amendment precluded a federal court from affording Rye any relief prior to its July 2, 1991 order, but any relief after that date would be prospective and not subject to the Eleventh Amendment bar. Specifically, respondents were ordered to comply fully with the applicable federal law and the July 2 order, and to recalculate Rye's rates as a disproportionate share hospital after July 2, 1991. A copy of the November 7, 1991 order is annexed hereto as Exhibit B.

21. Commencing as of July 2, 1991, respondents have failed and refused to add the five percent (5%) disproportionate share adjustment to which Rye is entitled by federal law although demand therefore has been made.

22. Furthermore, OMH has failed and refused to pay to Rye the difference between the amounts paid for 1987 through July 2, 1991 and the amount to which Rye is entitled, includ-

ing past and current disproportionate share adjustments, in the amount of $1,363,067, despite due demand therefore.

23. Respondents have taken the position in the federal court action that audits of Rye's cost reports, upon which the reimbursement rates for 1987 through July 2, 1991 are based, cannot be required and that there is no intention to audit them. Accordingly, Rye's reimbursement rates, without use of a minimum utilization factor, for those years are now final, and respondents are estopped from asserting otherwise.

24. Respondents' refusal to recalculate Rye's Medicaid reimbursement rates or to determine Rye's status as a disproportionate share hospital for the period January 1, 1986 to the present without use of the minimum utilization adjustment constitutes a failure to perform a duty enjoined upon them by 42 U.S.C. § 1396a(a)(13)(A) and is arbitrary and capricious.

25. Respondents' refusal to recalculate Rye's Medicaid reimbursement rates for the period January 1, 1986 to July 2, 1986, or to determine Rye's status as a disproportionate share hospital for the period January 1, 1986 to the present without use of the minimum utilization adjustment constitutes a denial of due process and equal protection of the laws in violation of the Fifth and Fourteenth Amendments to the Untied States Constitution. Respondents are liable to petitioner in such violations pursuant to 42 U.S.C. § 1983.

WHEREFORE, petitioner Rye Psychiatric Hospital Center, Inc., respectfully requests that this Court grant a judgment pursuant to Article 78 of the CPLR as follows:

(a) Directing respondents to discontinue the use of the "minimum utilization factor" in determining Rye's Medicaid rates for the years 1986 to July 2, 1991 and to include determination of Rye's entitlement to disproportionate share adjustment;

(b) Modifying the determination of Rye's 1986 through July 2, 1991 Medicaid rates and any payments made subsequent thereto and prior to the entry of a final judgment herein, so as to eliminate the application of the minimum utilization factor and include disproportionate share adjustments and, incidental thereto, awarding Rye damages in the amount of $1,548,801 with interest;

(c) Awarding Rye the costs and disbursements of this proceeding including its reasonable attorneys fees pursuant to CPLR § 8601 and 42 U.S.C. § 1988; and

(d) Awarding Rye such other and further relief as to the Court may seem just and proper.

Dated: New York, New York
February 7, 1992

RYE PSYCHIATRIC HOSPITAL CENTER, INC.

By: s/ JACK C. SCHOENHOLTZ
Jack C. Schoenholtz, M.D.

STATE OF NEW YORK)
: SS:
COUNTY OF WESTCHESTER)

JACK C. SCHOENHOLTZ, M.D., being duly sworn, deposes and says:

1. I am the President of the Petitioning Corporation in the above-entitled proceeding, I have read the foregoing amended petition and it is true to my knowledge except as to matters which are therein stated to be alleged upon information and belief, and as to those matters I believe them to be true.

s/ JACK C. SCHOENHOLTZ
Jack C. Schoenholtz, M.D.

Sworn to and subscribed before
me this 7th day of February, 1992

s/ Frederick A. Nicoll
NOTARY PUBLIC